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Series V Volume XIV No. 1 MARCH 1992

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The Emergence of Medical Malpractice in America

JAMES C. MOHR

Issues surrounding medical malpractice have come to dominate discussions of medical jurisprudence in the United States in modern times. Indeed, for a surprisingly large number of contemporary Americans, especially physicians, malpractice and legal medicine have become all but synonymous. A medico-legal world in which malpractice was not a prominent problem now seems to them both fancifully idealistic and almost inconceivable. It may come as a shock to many contemporary doctors and lawyers, therefore, to learn that medical malpractice litigation was not a serious medico-legal concern in the United States before 1840, even among the leading scholars of medical jurisprudence. But with striking speed thereafter, medical malpractice broke dramatically into American popular and professional consciousness to become a major issue for the nation's medico-legalists. Indeed, after 1850 medical malpractice would begin to alter the way physicians approached the subject of medical jurisprudence in America.

The basic concept of professional malpractice had existed in Anglo-American legal theory prior to the American Revolution, for William Blackstone referred specifically to malpractice in the famous *Commentaries on the Laws of England* he published during the 1760s. Moreover, Blackstone had linked the concept explicitly to the medical profession by including under *mala praxis* "Injuries . . . by the neglect or unskillful management of [a person's] physician, surgeon, or apothecary . . . because it breaks the trust which the party had placed in his physician, and tends to the patient's destruction."[1] The *Commentaries* were widely read in the colonies

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In a somewhat altered form, this article was presented at the Francis C. Wood Institute for the History of Medicine of the College of Physicians of Philadelphia on 28 February 1991, as part of the "Law and Medicine" program.

1. William Blackstone, *Commentaries on the Laws of England* (facsimile reprint of the first edition), Volume III, *Of Private Wrongs* (originally 1768), Chapter 8, p. 122. In various forms, of course, the concept of medical malpractice far predated Blackstone as well, though they are less germane to the situation in the United States. See, for example, Michael T. Walton, "The Advisory Jury and Malpractice in 15th Century London: The Case of William Forest," *Journal of the History of Medicine,* 1983, *40*:478–482.

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and remained influential through the early national period. But as a practical matter, actions for medical malpractice were seldom initiated in American professional situations through the first third of the nineteenth century. And even at a theoretical level, the concept of medical malpractice was so arcane and unimportant in the early republic that American writers on medical jurisprudence, those most likely to be interested in the subject as an aspect of legal medicine, did not bother to address it through the first four decades of the nineteenth century. Theodric Romeyn Beck's *Elements of Medical Jurisprudence,* by far the most authoritative and exhaustive treatise of the period, never mentioned malpractice from its first publication in 1823 through its mid-century editions, though the latter began to approach two thousand pages in length and were considered encyclopedic in the breadth of their coverage. Neither did standard legal treatises on evidence and proof.[2]

In 1834 Robert Eglesfeld Griffith of Philadelphia, one of the best-informed medico-legal writers and editors in the country, noted the total absence of any American study of "medical responsibility," by which he meant the standards of competence appropriate to various types of cases and various geographical regions. In fact, like many other physicians of the early period, he complained that the legal doctrines governing malpractice were too murky and unenforceable; complete charlatans could probably plead ignorance and escape the consequences of whatever harm they might do to fellow citizens.[3] As late as 1855, the first edition of Francis Wharton and Moreton Stillé's *A Treatise on Medical Jurisprudence,* which supplanted Beck's *Elements* as the dominant treatise in the field during the third quarter of the nineteenth century, still contained no reference to medical malpractice, though by then it probably should have.[4]

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2. Theodric Romeyn Beck's *Elements of Medical Jurisprudence* (Albany, N.Y.: Webster and Skinner, 1823), a world famous book, went through 12 editions between 1823 and 1863. For a key example from the legal literature, see Thomas Starkie, *A Practical Treatise on the Law of Evidence, and Digest of Proofs in Civil and Criminal Proceedings, With References to American Decisions, By Theron Metcalf,* 8th American edition from the 4th London edition (Philadelphia, Pa.: T. and J. W. Johnson, 1860). This multi-volume work, the most often cited in its field, does not address medical malpractice.

3. Robert Eglesfeld Griffith, review of Adolphe Trebuchet, *Jurisprudence de la médecine, de la chirurgie, et de la pharmacie, en France* (Paris: Baillière, 1834), in *American Journal of Medical Science,* 1834–1835, *15*:168–170.

4. Francis Wharton and Moreton Stillé, *A Treatise on Medical Jurisprudence* (Philadelphia, Pa.: Kay and Brother, 1855).

This is not to say that medical malpractice cases were completely unknown in the United States before the year 1840. In 1827, for example, the Beck brothers' *New York Medical and Physical Journal* reported a case of obvious and special interest to those who urged closer cooperation between the medical profession and the government. The events that led to the case had taken place in 1824. That spring the City of New York hired physicians to canvass Manhattan by districts and vaccinate at public expense anyone who had not already been protected against a cresting epidemic of smallpox. One of the physicians hired, a young practitioner named Gerard Banker, vaccinated some 870 citizens in his district, many of whom were children. One of those children, a two-year-old, subsequently died a hideous and horrible death from the disease, and the child's father sued Banker for inflicting smallpox upon the child through a bad inoculation.[5]

Though Banker was acquitted when other city physicians testified that the child was probably coming down with the disease at the time Banker performed the vaccination, the case might have had a chilling effect upon future cooperation between the medical profession and public authorities had the decision gone the other way; that was no doubt the reason the *New York Medical and Physical Journal* publicized the case. Moreover, Banker's defense attorney had also tried to make as plain as possible to individual physicians the potential danger of this sort of accusation. "The case is of vast importance to the defendant," he argued, because the young doctor had "chosen a profession, to the study of which, he has already devoted many years of his life, and a verdict in this case against him, is his professional death."[6]

Other scattered cases occurred during the 1820s. Two obscure practitioners in Maine, for example, were sued in a case involving the treatment of a hip injury incurred in 1821. That case dragged on nearly five years, gained national attention, and eventually pitted John Warren, a leader of the Boston medical establishment, against Nathan Smith, a New England rival who helped establish both the Dartmouth Medical School and the Yale Medical School, at least in part to offset the dominance of the Harvard-based Boston group.

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5. "Michael O'Neil vs. Gerard Bancker," *New York Medical and Physical Journal,* 1827, 6:145–152. Irregularities occur in the spelling of the physician's name, but it is rendered throughout the text of the story as Banker. That spelling will be used here.

6. "Michael O'Neil vs. Gerard Bancker," p. 151.

Yet reports of the case revealed clearly that one of the chief reasons for its notoriety lay in its novelty. Indeed, attorneys in the case were not sure exactly how to phrase the court action they were trying to take.[7] Later in the decade Nathan Smith told his medical jurisprudence class at Yale about that case and about a small handful of other malpractice actions that he was aware of in Connecticut during the 1820s. But Smith, who had been personally involved in the most famous medical malpractice case in the nation's history to that time and who was in a position to know such things, remarked to his Yale students that he "Never knew but one case sued for Malpractice in medicine [as distinguished from surgery]," and he seemed to suggest that more aggressive legal activity on the malpractice front might prove salutary for the medical profession in the long run, since under the doctrines in force in Connecticut in 1827, "the most egregious Quacks must escape punishment."[8]

Notwithstanding the foregoing examples, then, malpractice cases involving physicians were sufficiently few in number through the first 50 years of the republic to be reasonably characterized as isolated, though sometimes troubling, curiosities.[9] Certainly medi-

7. Many of the principals in this well-known case, *Lowell v. Hawks and Faxon*, ended up publishing their own version of what they considered most important about the affair. See, for example, Charles Lowell, *An authentic report of a trial before the Supreme judicial court of Maine, for the county of Washington, June term, 1824: Charles Lowell vs. John Faxon & Micajan Hawks, surgeons and physicians, in an action of trespass on the case for ignorance and negligence* (Portland, Maine, 1825); Charles Lowell, *Report of the trial of an action, Charles Lowell against John Faxon and Micajah Hawks, doctors of medicine, defendants, for malpractice in the capacity of physicians and surgeons, at the Supreme judicial court of Maine, holden at Machias for the county of Washington — June term, 1824. Before the Hon. Nathan Weston, Jun., Justice of the court* (Portland, Maine: James Adams, Jr., 1825); and the public letter issued by John C. Warren: *A Letter to the Hon. Isaac Parker, Chief Justice of the Supreme Court of the State of Massachusetts, Containing Remarks on the Dislocation of the Hip Joint, Occasioned by the Publication of a Trial which took place at Machias, in the State of Maine, June, 1824* (Cambridge, Mass., 1826).

8. " 'Medical Jurisprudence' by Nathan Smith," lecture notes by Avery J. Skelton taken at Yale University; probably in February 1827, p. 138. Manuscript Collection, History of Medicine Division, National Library of Medicine, Bethesda, Maryland.

9. The standard essay on this subject for some time has been Chester R. Burns, "Malpractice Suits in American Medicine Before the Civil War," *Bulletin of the History of Medicine*, 1969, *43*:41–56. Burns, in turn, had benefitted from the surveys by Hubert W. Smith, "Legal Responsibility for Medical Malpractice, IV: Malpractice Claims in the United States and a Proposed Formula for Testing Their Legal Sufficiency," *JAMA*, 1941, *116*:2670–2679, and Andrew A. Sandor, "The History of Professional Liability Suits in the United States," *JAMA*, 1957, *163*:459–466. More recently, Kenneth A. De Ville completed a monograph that has added enormously to this and related inquiries about medical malpractice in the United States during the nineteenth century. De Ville was kind enough to share his

cal journals, even though they had a *prima facie* interest in malpractice developments and even though they evinced a strong and growing interest in most other types of medico-legal topics after 1820, rarely mentioned malpractice cases prior to 1840 and did not betray any special misgivings about the isolated ones they happened to come across. The precise number of medical malpractice actions at any given point in the century cannot be determined. Even if armies of patient researchers were available to survey all legal actions in all jurisdictions at all levels, many, if not most, of the records were never saved in the first place or have subsequently been lost or destroyed. Consequently, despite obvious drawbacks, legal historians have used state appellate cases as a sort of statistical surrogate in situations of this sort. By that measure, only 2 percent of the medical malpractice cases to reach American state appellate courts between 1790 and 1900 were reported in the period before 1835.[10] Kenneth De Ville, who has made the most recent and most thorough assessment of those cases, also noted that the period from 1790 to 1840 was the only period in American history in which the rate of population growth easily exceeded the rate of increase in medical malpractice cases.[11]

After 1840, the frequency of malpractice actions shot suddenly upward, and well-established physicians, not charlatans, found themselves the targets of an almost revolutionary and certainly unprecedented surge in malpractice accusations. As a result, what had appeared for half a century to be a potentially beneficent curiosity was transformed in the perception of well-educated regular American physicians in less than a decade into an anti-professional specter of high visibility and ominously destructive power. That change in the role of medical malpractice in American professional life, in turn, quickly proved to be yet another of the mid-century

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manuscript with me prior to its publication. References here are to that manuscript. The book itself, which is now available, is Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* (New York: New York University Press, 1990).

10. De Ville, *Medical Malpractice,* pp. 1–5. The 2.3 percent represented 5 of the 216 total cases. What percentage of all medical malpractice cases reached appellate courts, of course, is also impossible to judge. There is some reason to use a 1 percent ratio for later periods, but that seems a bit low for the early period, when malpractice cases, precisely because they were oddities, might more likely be appealed. In any event, it seems safe to state that fewer than five hundred medical malpractice actions were brought in all American courts combined prior to 1835, and the total might very probably be much lower than that.

11. De Ville, *Medical Malpractice,* pp. 4–5 and Table 1.

developments that widened the gap between law and medicine and pushed the field of medical jurisprudence farther toward the margins of American professional development.

Though historians have only begun to explore this striking and intriguing transition, some of the broad outlines of what happened are relatively clear. The same socio-political and ideological ethos that blocked state support for medical jurisprudence during the 1830s had begun by the 1840s to transform physicians from community helpers into contract agents. Doctors no longer looked like designated healers or well-meaning neighbors who served their local communities as best they could in an interactive and organic social system that involved mutual trust and obligations. Instead, doctors looked more and more like individual entrepreneurs in an intensely competitive marketplace. Under those altered circumstances, increasing numbers of patients decided that the physician-agents they retained could have and should have done a better job than they did. Rather than pay their doctors for doing as well as they could under the conditions at hand, an increasing number of patients instead sued their doctors for failing to prevent or for apparently inflicting permanent disabilities and deformities, for failing to deliver on an implied contract of full recovery or restoration.

Shifting public attitudes may also have been fueled by perfectionist health and fitness movements that swept the nation during the 1840s, for those movements almost certainly raised people's expectations of what was considered normal in matters of health and made people more sensitive to physical well-being. Some historians argue that the era also experienced a corresponding decline in the number of people still prepared to dismiss bodily suffering in a religiously fatalistic fashion. A surge of aggressive and flamboyant medical advertising during the late 1830s and early 1840s offered the general public a host of false promises, further adding to general expectations. The steady nationalization of the new medical marketplace probably also played a role in the advent of widespread malpractice litigation, for standards of care once considered not only adequate but uniquely appropriate to a particular local region began to seem inferior and erroneous in comparison to results claimed or obtained elsewhere. Changes in the technical rules of legal pleading

during this same period, moreover, had the effect of further easing the process of bringing malpractice actions in the first place.[12]

In any event, the new "contagion" of lawsuits, as physicians characterized the phenomenon in a typically medical metaphor, seemed to become virulent almost overnight. At first centered in western New York State, a sharp surge in the frequency of malpractice cases was evident throughout New England and the upper Mid-West by mid-century. Even though exact numbers for the period remain impossible to calculate, and even though the rates of malpractice actions were probably lower than they have come to be in the twentieth century, the evidence is overwhelming that "the profession and the country crossed over the most critical threshold in the 1840s and 1850s."[13] Malpractice cases carried to state appellate courts roared ahead 950 percent between 1830 and 1860, while the nation's population increased 144 percent, and almost all of the increase in malpractice appeals took place after 1840.[14] Medical journals, after decades of barely noticing malpractice on the medical horizon, reacted defensively with strong and frequent articles and editorials.

The public's increasingly frequent recourse to medical malpractice suits in the 1840s may be seen in retrospect as a perfectly reasonable response to the marketplace professionalism which was then emerging in the United States. Anti-monopolistic sentiment during the 1830s, after all, had precluded the creation of professional structures that might have permitted some degree of self-regulation by the medical profession: structures such as licensing qualifications to insure minimal competence or government-appointed physicians to provide a public standard. Halting experiments designed to encourage internal settlements within local medical societies proved quickly and utterly ineffectual in the face of intense personal rivalries inside the societies and accusations from healers outside the societies.[15] Consequently, individual practitioners, one at a time, would have to be held to standards deemed acceptable by those who retained their services. Quality control

12. De Ville, *Medical Malpractice,* discusses many of these and other factors. On the erosion of therapeutic differences by region, see John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820–1885* (Cambridge, Mass.: Harvard University Press, 1986).

13. De Ville, *Medical Malpractice,* p. 45.

14. De Ville, *Medical Malpractice,* Table 1, p. 4.

15. "Doings of the Courtland County (New York) Medical Society," *Boston Medical and Surgical Journal,* 16 February 1842, 26:33–34.

would come not from self-policing by medical providers, since that was too dangerous for other reasons and historically ineffective in any event, but from the people who paid the bill. Indeed, if the concept of medical malpractice had not already existed in Anglo-American legal theory, Americans might have been forced to invent it; in seizing upon an arcane doctrine and changing the rules of pleading to ease its employment, Americans essentially did just that.

At least in theory, the nation's strongest physicians might have welcomed the sudden and dramatic increase in the number of malpractice suits as a useful alternative method of driving charlatans and amateur hacks from the field. The general public and the legal profession might have been enlisted as allies in an effort to improve medical care. The early champions of medical jurisprudence, after all, had cautiously endorsed the positive potential of malpractice litigation and envisioned lawyers not as hostile attackers but as partners in a process of professional purification. Over and over during the 1840s and 1850s, however, the nation's best-educated and most professionally-minded physicians observed with a sort of defensive incredulity and disbelieving horror that many, if not most, of the burgeoning numbers of malpractice suits were being lodged not against charlatans and amateur hacks, but against others like themselves: successful regular doctors. What early commentators like Griffith and Smith once considered a potentially useful mechanism had somehow quickly and alarmingly come to be a means of persecuting the best physicians then practicing.

Several factors help explain why the best-educated and most successful physicians, rather than the nation's army of amateurs and alternative healers, became disproportionately frequent targets for malpractice suits in the 1840s. First, they became ironic victims of their own medical advancement. The vast majority of the lawsuits that constituted the first great wave of malpractice litigation at mid-century involved orthopedic cases in which a limb had healed to a shortened, deformed, or frozen position following compound fracture. Patients found themselves with an unambiguous, easily demonstrated, and obviously measurable problem and sued the doctor who set the bone fragments and dressed the wound. What made this situation ironic was the fact that 20 years earlier most compound fractures would have led to amputation. The patient would have no limb at all, but no malpractice case either, since the doctor would have been following safe and standard procedures. Improved techniques and more careful training produced an ad-

vance; but because the consequences of the advance were often imperfect, those who tried to save limbs in difficult cases often found themselves being sued.

Second, the better the physician, the more likely he would be to take a difficult compound fracture case in the first place and the more likely he would be to try to save the limb, even if it survived in less than perfect shape. The techniques involved in saving compound fractures in the 1830s, while still avoiding the dangers of internal infection that previously made amputation necessary to save the life of the patient, required sophisticated knowledge of wound dressing and bone setting that amateurs or inexperienced healers would never pretend to possess.

Third, amateurs and alternative healers delivered what patients came to them for, be it hot baths or herbal teas, and could not be sued for undesirable results (in theory they could have been sued for concocting their own teas erroneously, but in practice they claimed no standard recipes and made a virtue of treating each case individually). Regular physicians, on the other hand, could have the very body of educational texts and advanced manuals they were steadily producing used in court against them as standards or norms from which they could be accused of deviating. William Rothstein and others have pointed out the sometimes deceptive truism that *malpractice* is virtually impossible to demonstrate in the absence of *practice*; no one can be convicted of doing established procedures poorly, if no procedures have been established.[16] Writing from Erie, Pennsylvania, in 1849, William Wood, a United States Navy doctor, understood the frustrations of that principle all too well. "It is better to be without a diploma" in the current climate, he concluded ruefully, because then a "practitioner can say, 'I make no pretensions, I offer no certificate of ability, and only gave my neighbour in his sufferings such aid as I could.' "[17]

Finally, patients had little or no incentive to sue marginal healers with few assets, but substantial incentive to sue the most prosperous physicians, from whom they might actually collect. That incentive, superimposed upon the anti-elite, anti-monopoly, and

16. William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore, Md.: The Johns Hopkins University Press, 1972), pp. 324–325.

17. William Wood, "Thoughts on Suits for Malpractice, Suggested by Certain Judicial Proceedings in Erie County, Pennsylvania," *American Journal of Medical Science*, 1849, *18*:400.

anti-professional ethos of the 1830s and 1840s, gave the nation's first medical malpractice crisis a distinctly class-oriented aspect. Physicians near the top of their profession certainly saw class as a factor in the crisis. Many of them thought that the vast majority of malpractice suits were initiated by poor patients either trying to escape paying for a job they considered less than perfect or trying to turn a misfortune into cash at the expense of a wealthy professional. Medical societies reconsidered their obligations to treat the poor; impecunious patients were made to post bonds against subsequent legal actions before receiving medical treatment; and medical spokesmen railed against the use of a long-dormant legal doctrine for the purpose of shaking down the nation's better physicians, since a doctor often found it easier to forgive the bill or settle a claim out of court than to fight the accusation and risk his reputation and his whole practice.[18]

In a most revealing comment, Walter Channing at Harvard was appalled at reports of "a certain county, of a certain State, [where] the jury in all suits for malpractice give their verdict for the plaintiff; and that same county, it is said, tries more of such cases than all the others of the *Commonwealth* put together."[19] Under the circumstances, Channing's pointed emphasis of the word commonwealth was almost certainly intended to be mocking. The concept of society which that hopeful word once evoked for republican state-makers in an earlier era, Channing was suggesting, no longer seemed to exist in the United States by the middle of the nineteenth century.

Channing had become convinced that the only antidote to the malpractice contagion would be the creation of special medical juries to try malpractice accusations. Other professions already enjoyed that perfectly reasonable and logical privilege in the Anglo-American legal tradition, he argued. "In both army and navy, officers are tried by their peers — by themselves," and clergy, when challenged on questions "relating to their profession," were judged by other clergy. But the citizens who ended up on ordinary American juries were in no sense peers of the physicians whose efforts they

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18. De Ville, *Medical Malpractice,* pp. 373–459. All of these trends are evident as well in many articles that appeared during the 1840s and 1850s in the nation's leading contemporary medical journals.

19. Walter Channing, "A Medico-Legal Treatise on Malpractice and Medical Evidence — A Review," *Boston Medical and Surgical Journal,* 1860, 62:306; emphasis in the original.

were now being asked to assess. Common juries tended not to evaluate physicians, but to attack them.[20]

The malpractice crisis of mid-century also widened the gap between physicians and lawyers. That gap had already been opened by previous professional confrontations over expert medical testimony, but quickly became a chasm in the context of malpractice. Many prominent physicians believed that the general public, and especially the poor, would not be attacking the doctors who helped them, often for little or no fee, unless they were incited by self-seeking and professionally irresponsible attorneys. By mid-century, the *Boston Medical and Surgical Journal* was referring to geographical areas where actions for malpractice proliferated as "law-infected districts."[21] And there is some evidence that lawyers did encourage one another to keep expanding what appeared to be a new growth market for their services. In 1849, for example, the *American Law Journal* noted with disgust that the death of a patient during neck surgery had been ruled accidental. The *Journal* suggested that the same standards of liability should apply in medical cases that applied in any other dangerous trade. The editor likened physicians to boiler mechanics: the former should be as liable as the latter if clumsiness or lack of real knowledge led to an explosion.[22] The *Journal* likewise considered deaths and complications that followed the administration of anesthetics, which were just beginning to come into widespread use among American physicians, a potentially fertile new field for lawyers to cultivate more aggressively.[23]

Physicians particularly deplored the contingent fee system, which lawyers began to employ frequently in the middle decades of the nineteenth century in malpractice cases. Under that system plaintiffs risked nothing in bringing charges, then split with their attorneys some portion of any judgment they were able to win in or out of court. Physicians denounced those arrangements and tried repeatedly to have them declared illegal or unethical. But they gained little headway in the face of egalitarian arguments that every citizen had the right to bargain for legal representation on the best

20. Channing, "Medico-Legal Treatise," pp. 233–241, 259–265, and 300–307.

21. "Medical Miscellany," *Boston Medical and Surgical Journal,* 20 February 1850, *42*:67.

22. *American Law Journal,* 1849, *1*:284–285.

23. *American Law Journal,* 1849, *1*:284; 1849–1850, *2*:330–333. On the adoption of anesthetics, see Martin Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985).

terms available, whether cash was in hand or in prospect. By the 1880s the American Medical Association regarded "a large proportion" of malpractice actions as having "no other foundation than a desire to extort money from the defendant sufficient to secure a good fee for the prosecuting counsel."[24] Medical journals likewise castigated what they considered to be illegal fishing expeditions long after the fact, since litigants during the 1840s were beginning to receive large settlements for alleged suffering that occurred years after the operation at issue had been performed.[25] Physicians were appalled in the early 1850s when lawyers also began to sue physicians for what they did *not* do, thereby cashing in on an implied responsibility to treat the public that popular newspapers of the 1850s also asserted.[26]

The expression of anti-lawyer sentiments, which had not been a strong theme in doctors' discourse before 1840, became both common and blatant after mid-century whenever physicians discussed malpractice. To cite a single prominent example, Eugene Sanger, a physician whose 1878 survey of medical malpractice in Maine was one of the most systematic of the early sources of information about the growing phenomenon, believed that malpractice attorneys "follow us as the shark does the emigrant ship."[27] Many of his fellow physicians before him and after were less metaphorical and less subtle. It would be easy to fill several hundred pages full of vituperative, anti-legal rhetoric from medical journals after mid-century, but there is little reason to do so here. In the twentieth century, Americans have become accustomed to strained relations and strong opinions whenever physicians discuss lawyers in the context of malpractice. Suffice it to say that the origins of those now axiomatic sentiments lie in the period between 1840 and 1860.

The malpractice crisis also began to reshape the teaching of medical jurisprudence in medical schools. To oversimplify, medical students no longer wanted their professors of medical jurisprudence

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24. *JAMA*, 1887, p. 839.

25. "Medical Miscellany," *Boston Medical and Surgical Journal*, 7 October 1846, *35*:207.

26. "Liability of Physicians and Surgeons," *Boston Medical and Surgical Journal*, 20 July 1853, *48*:506–507.

27. The quote is from "Medical Notes," *Boston Medical and Surgical Journal*, 1878, *100*:91. The larger report is Eugene F. Sanger, "Report of the Committee on Suits for Malpractice," *Transactions of the Maine Medical Association*, 1878, 6:360–382.

to tell them how to become more effectively involved in the nation's legal system; they wanted to know how to avoid involvement altogether or at least how to escape with minimal disruption. A near perfect illustration of that long-term shift within medical schools occurred at the Geneva Medical College exactly at mid-century.

The place, the professor, and the date all seemed symbolic. Geneva Medical College, then a prominent institution with a faculty considered among the most able in the nation, was located squarely in the middle of western New York, the area in which the malpractice crisis seemed to originate.[28] By the middle of the 1840s, in fact, western New York had already gained a legendary reputation, in the oft-quoted characterization of the *Boston Medical and Surgical Journal,* as "dangerous ground for a surgeon."[29] An especially nasty malpractice case in nearby Cortland in 1841 had dragged on for years and disrupted the region's local medical societies.[30] Frank Hamilton, the well-educated and prominent physician from Buffalo who would eventually publish data demonstrating statistically predictable variations in compound fracture cases in order to undercut what he considered to be the unrealistic claims of those whose healing had been less than perfect, estimated that nine out of every ten physicians in western New York had been charged with malpractice by mid-century.[31] The students at Geneva, many of whom no doubt hoped to practice in the otherwise prosperous and economically attractive districts of western New York, could not have been unaware of the malpractice crisis.

The professor who taught medical jurisprudence at Geneva through most of the 1840s was James Webster, a prototype of the able young professionals who had been drawn to the field in the 1820s and 1830s. Webster had earned his M.D. from the College of Physicians of Philadelphia (University of Pennsylvania) in 1824. There, in the afterglow of such leading medico-legalists as Benjamin

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28. On Geneva Medical College at this time, see William F. Norwood, *Medical Education in the United States before the Civil War* (Philadelphia, Pa.: University of Pennsylvania Press, 1944), pp. 155–159, 164, and 411–412.

29. "Accusation of Mal-practice," *Boston Medical and Surgical Journal,* 1844, *31*:123.

30. This case, *Smith v. Goodyear and Hyde,* is developed at length by De Ville, *Medical Malpractice,* pp. 281–302, and may easily be tracked in detail through the medical journals and regional newspapers of the period.

31. De Ville, *Medical Malpractice,* pp. 200–203 and 277; Frank H. Hamilton, *Fracture Tables* (Buffalo, N.Y., 1853); and James H. Cassedy, *American Medicine and Statistical Thinking, 1800–1860* (Cambridge, Mass.: Harvard University Press, 1984), pp. 87–88.

Rush, Charles Caldwell, and Thomas Cooper, and under the direct influence of Robert Eglesfeld Griffith, Webster wrote his dissertation on medical jurisprudence. The thesis summarized the field as it then appeared to an enthusiastic student. Webster thought medical jurisprudence in 1824 had "assumed a more imposing aspect" than it ever possessed before and was becoming recognized as an "indispensable" element of future professional training in the United States.[32]

For 25 years, through 1849, Webster maintained his commitment to medical jurisprudence as Beck and Griffith had conceived of it. He taught the subject in Philadelphia through 1835 and in New York City from 1835 through 1842. In the latter city he delivered a course of lectures on medical jurisprudence to the Bar of New York. In 1842 Webster went to Geneva as professor of anatomy and medical jurisprudence, and when asked to deliver the ceremonial introductory lecture shortly thereafter, he had, in his own words, taken "the occasion to endeavor to impress upon the minds of a former class, my sense of the deep importance of a clear and accurate knowledge of the principles of Medical Jurisprudence to the practising physician and surgeon."[33]

In the spring of 1850 Webster was again asked to deliver the ceremonial lecture that opened each term. And as he had in the past, Webster again took up the subject of medical jurisprudence. But this time, exactly at mid-century, his tone shifted dramatically. Until he came to Geneva, Webster stated, he had never encountered a malpractice case, though he had frequently been an expert witness in medical cases of almost every other sort. In recent years, however, the subject of malpractice had come to overshadow all other aspects of legal medicine. As a result, the optimism and excitement that Webster himself had enjoyed as a student when he contemplated the possibilities of combining medicine and law in the public interest had come to be replaced in the minds of his Geneva students 25 years later by fear and misgiving. Responsible teachers of medical jurisprudence in western New York in 1850 could no longer afford noble dreams, Webster suggested to his students; the time had come

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32. James Webster, Jr., *Medical Jurisprudence* (Philadelphia, Pa., M.D. thesis, submitted 8 April 1824; now bound with Miscellaneous Theses, College of Physicians of Philadelphia, Vol. 1), p. 2.

33. James Webster, *Introductory to the Course on Anatomy, in Geneva Medical College, March 7th, 1850* (Geneva, N.Y.: E. Van Volkenburgh, 1850), p. 6 (now in the pamphlet collection, College of Physicians of Philadelphia).

to face up to the fact that medical jurisprudence courses had to address "the darker side of your professional prospects."

Once a champion of active involvement, Webster now felt obliged to suggest "a remedy" to avoid "the attacks of the unprincipled, . . . escape persecution, and protect yourselves from the assaults of the unworthy upon your professional reputations, as well as your peace and comfort, to say nothing of your property, if you should be so fortunate to accumulate any."[34] His advice was to refuse fracture cases among the poor. If the graduates proved unable to "sacrifice . . . the best feelings of your nature," and took such cases anyway, counselled Webster, at least make certain that "judicious witnesses" wrote down everything you did and kept independent ongoing records of the case.[35] What a far cry from the idealistic hopes, humane sentiments, and cooperative assumptions that infused the *Elements* a quarter of a century earlier and drew Webster himself to the field.

What happened at Geneva exactly at mid-century was repeated in less dramatic ways throughout the United States in the decades that followed. Legal medicine became so intertwined with the question of medical malpractice that students and professors alike began to emphasize not the positive interactions envisioned in previous decades, but practical tactics to minimize the involvement of physicians in legal processes. Practitioners grew less tolerant of idealistic exhortation about the ways in which law and medicine ought to cooperate and more demanding of tactical advice about staying out of legal trouble.

Two books that appeared in 1860 neatly epitomized the transition. The first was the 11th edition of the Becks' *Elements*. Prepared by friends and colleagues of the late Beck brothers, the 11th edition contained a good deal of new material added by a number of experts in their particular areas of interest.[36] Edward Hartshorne, a distinguished scholar of medical jurisprudence himself and the American editor of several English texts on the subject, reviewed the new 11th edition for the *American Journal of Medical Science*. He knew "no single work on a subject relating to medical science

34. Webster, *Introductory to the Course on Anatomy,* pp. 6–7.

35. Webster, *Introductory to the Course on Anatomy,* pp. 6 and 12.

36. Chandler Robbins Gilman, who was professor of medical jurisprudence at the College of Physicians and Surgeons of New York, took the editorial lead in the preparation of the 11th edition, but at least 15 other medical scientists also contributed to the effort.

. . . so full of varied and absorbing interest to every class of readers," as the *Elements*. Moreover, the book remained "the most comprehensive and complete upon its subject in the English language." But Hartshorne stressed twice in his relatively short discussion the telling fact that the *Elements* had become essentially "a work of reference." Hartshorne expressed the hope that future teams of editors and revisers would keep the *Elements* up-to-date and in print as a reference tool, primarily because the material it contained should be kept "within the reach of medical jurists."[37]

Hartshorne's observation that the 11th edition of the Becks' book was useful principally to "medical jurists" was in a subtle way quite damning; by implication the book was no longer central to the concerns of most ordinary practitioners. In fact, there would be only one more edition, the 12th, published in 1863, and it was essentially a reprint of the 1860 edition with a couple of small additions. From a virtual manifesto in 1823, the *Elements* by 1860 seemed ponderous, old-fashioned, and somewhat marginal. In its place appeared a book with an altogether different tone: John J. Elwell's *A Medico-Legal Treatise on Malpractice, Medical Evidence, and Insanity, Comprising the Elements of Medical Jurisprudence.*

Citing the surge of malpractice actions in the previous 15 years and stressing the fact that the malpractice crisis seemed to be spreading, not receding, Elwell wanted "to strip the subject [of medical jurisprudence generally] of all . . . profitless details" and "speculative themes" in order "to furnish the medical man that necessary information respecting his legal responsibility as a practitioner and witness which he has been hitherto unable to obtain, except by the general study of law."[38] If a previous generation of doctors had needed and responded to Beck's idealistic and erudite suggestions about interesting ways to get involved with the law, the nation's physicians now needed something much more pressing: knowledge to "protect themselves from unjust prosecutions while in the legitimate pursuit of their calling."[39] Some medical societies had been

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37. Edward Hartshorne, "Art. XXXII," *American Journal of Medical Science*, 1860, *39*:211–212.

38. John J. Elwell, *A Medico-Legal Treatise on Malpractice and Medical Evidence Comprising the Elements of Medical Jurisprudence* (New York: Voorhis & Co., 1860), "Preface," pp. 7–9, 10, and 12.

39. Stephen Smith, "Art. XV," *American Journal of Medical Science*, 1860, *40*:155.

calling openly for such a study during the 1850s;[40] and, using excerpts from recent malpractice cases, that was exactly what Elwell tried to give his readers. *A Medico-Legal Treatise on Malpractice,* the first serious study of its sort in the United States, thus became the first book in what would eventually be a long tradition of defensive medical jurisprudence.

Numerous review essays and an outpouring of testimonials demonstrated that Elwell had touched a sensitive nerve. Walter Channing, who had taught medical jurisprudence in the tradition of Rush and Beck at Harvard before malpractice provoked his disillusionment with the field, now wrote Elwell to congratulate him on "this important addition to our professional literature" and prepared a pamphlet to alert other physicians to the excellence and significance of Elwell's volume.[41] John Ordronaux, who would shortly rise to the top ranks of New York's medico-legal experts, hailed Elwell's *A Medico-Legal Treatise on Malpractice* as an outstanding work that met the most "pressing deficiency in any department of medico-legal literature."[42] The aging Robley Dunglison recommended the book to his class at Jefferson Medical College.[43] Dozens of others, including lawyers and judges, joined the chorus. The *Boston Medical and Surgical Journal,* the *Cleveland Medical Gazette,* the Cincinnati *Lancet and Observer,* the Cincinnati *Medical and Surgical News,* the *Chicago Medical Journal,* the *New York Journal of Medicine,* the *American Medical Gazette,* the *American Journal of Pharmacy,* the *Boston Law Reporter,* and a surprisingly large number of regular daily newspapers, including the *New York Herald* and the *New York Times* praised the important professional job Elwell had performed.[44]

And even as the grand old *Elements* began to fade from view, the standing of Elwell's *A Medico-Legal Treatise on Malpractice* soared. A second edition was issued in 1866, a revised third in

40. See, for example, the resolution of the Medical Association of Southern Central New York, reprinted and endorsed in *Boston Medical and Surgical Journal,* 5 July 1855, *52*:444.

41. Walter Channing to John J. Elwell, 16 May 1860, reprinted in the front matter of the 1866 edition of Elwell's *A Medico-Legal Treatise on Malpractice.* For Channing's long, favorable review of the book see *Boston Medical and Surgical Journal,* 1860, 62:233–241, 259–265, and 300–307.

42. John Ordronaux to John J. Elwell, 8 March 1860, reprinted in the front matter of the 1866 edition of Elwell's *A Medico-Legal Treatise on Malpractice.*

43. Robley Dunglison to John J. Elwell, n.d., reprinted in ibid.

44. Excerpts from these reviews are reprinted in the 1866 edition of Elwell's *A Medico-Legal Treatise on Malpractice.*

1871, and a revised fourth in 1881. Discussions of Elwell's *A Medico-Legal Treatise on Malpractice* confirmed the existence of the growing gulf between law and medicine, a gulf that the early champions of medical jurisprudence had either not foreseen or tried to bridge. The *New York Medical Press,* for example, thought Elwell's book signalled an important new departure in the literature on law and medicine because it faced straightforwardly the reality that now presented itself. Law and medicine had evolved into mutually incompatible professions. Consequently, "It is . . . *necessary* that [a doctor] knows what he should say and do in a contingency which may happen, and unexpectedly, any time," especially in "civil suits for malpractice." Unfortunately, "none of the medical jurisprudences [i.e., previous works on the subject] have been at all sufficiently practical" in such matters, and the medical profession, as a result, was suffering. Elwell helped doctors bridge the "chasm" between the professions, rather than fall into it. The *Press* considered Elwell's material valuable for lawyers, but absolutely "paramount to our medical brethren."[45]

Even those few experts in medical jurisprudence who disliked Elwell's approach to the subject acknowledged the fact that he and his book signalled something of a new era for the field. Stephen Smith, a medical activist, public health crusader, and politically-minded professional who embraced broad views of professional interaction and became influential in New York City health policy and New York State medical reform after the Civil War, was among Elwell's few unenthusiastic reviewers. Smith may simply have been disappointed that Elwell got there first, however, for Smith had been at work on a similar volume himself.[46] Nonetheless, Smith ended his long analytical discussion of *A Medico-Legal Treatise on Malpractice* with a begrudging recognition that Elwell had "done much to establish the principles which are to lead to the development of malpractice in medicine as an important branch of medical jurisprudence."[47] Smith could hardly have known how prescient that was.

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45. "Notice" of Elwell's *A Medico-Legal Treatise on Malpractice and Medical Evidence: Comprising the Elements of Medical Jurisprudence, New York Medical Press,* 1860, *3*:141–142.

46. *Boston Medical and Surgical Journal,* 5 July 1855, *52*:444.

47. For Smith's activities as a health reformer, see James C. Mohr, *The Radical Republicans and Reform in New York during Reconstruction* (Ithaca, N.Y.: Cornell University Press, 1973), pp. 61–85. Smith's review of Elwell's *A Medico-Legal Treatise on Malpractice* appeared as Stephen Smith, "Art. XV," *American Journal of Medical Science,* 1860, *40*:153–166. The quote is from p. 166.

Elwell's work was quickly joined in the medico-legal marketplace by nationally important and well-received studies that accepted most of his priorities and tried to improve upon his understanding of malpractice. The best of them was Ordronaux's own book, *The Jurisprudence of Medicine in its Relation to the Law of Contracts, Torts and Evidence,* which appeared in 1869. Like Elwell, Ordronaux held formal degrees both in law and in medicine. He had graduated from Harvard Law School in 1852, then studied medicine later in the decade with the specific purpose of taking up medical jurisprudence as a specialty. He was appointed to a chair in the subject at Columbia Law School in 1861 and continued to teach there until the end of the century. Also like Elwell, Ordronaux projected a cautious and defensive attitude toward his own specialty.[48] Milo McClelland's popular *Civil Malpractice,* which appeared in 1873, further emphasized the fact that the dangers of litigation had become the central concern of medical jurisprudence.[49]

By the end of the nineteenth century, medico-legal experts were lionized in the medical profession not for their contributions to justice in the American republic, but for their ability to defend physicians against charges of malpractice. The well-known *National Cyclopaedia of American Biography* specifically recognized in its index only four individuals prominent during the late nineteenth and early twentieth centuries for their efforts in the field of medical jurisprudence. One was Ordronaux (1830–1908). Another was James T. Lewis (1865–1935), who engineered a merger of New York's two rival medical societies in the early 1920s and "defended many of the most prominent medical men in the state and argued cases before many courts. The successful defense of over one thousand medical malpractice actions earned him general recognition as a man with a unique combination of medical and legal talent."[50]

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48. On Ordronaux see *National Cyclopaedia of American Biography, 12*:331–332; *Dictionary of American Biography, 7*:50–52.

49. Milo McClelland, *Civil Malpractice* (New York, 1873). This was a reprint for national publication of a report McClelland had done on malpractice for the Chicago Medical Society.

50. *National Cyclopaedia of American Biography, 27*:352. After his retirement in 1924, interestingly enough, Lewis switched sides and took "numerous malpractice actions, this time on behalf of the plaintiff." The other two people singled out for work in the field of medical jurisprudence were James W. Putnam, the AMA president and neurologist who was considered among the nation's leading authorities on the forensic aspects of insanity, and William C. Woodward, the Washington, D.C., sanitation reformer who also taught medical jurisprudence for many years at Georgetown and other universities.

The small number of people whose chief fame resulted from medical jurisprudence was striking enough in itself, but even more significant is the fact that half the tiny group, Ordronaux as a theorist and Lewis as a practitioner, owed much of their fame as medico-legal experts to their involvement in the question of malpractice.

The great wave of malpractice suits never really ebbed. If anything, it increased both in absolute numbers and in rates relative to population. Initial panic abated somewhat as physicians moved to counter the specific accusations associated with orthopedic surgery, largely through statistical analyses of reasonable success rates. Physicians also began to experiment with various self-protective mechanisms, including medical society legal defense funds, medical society pledges of mutual defense, and the first malpractice insurance schemes.[51] In that context, the rise of malpractice litigation at mid-century certainly helped accelerate cooperation and consolidation among American physicians.[52]

It would be ahistorical, though certainly tempting in light of twentieth-century developments, to overemphasize the impact of the nation's first malpractice crisis on the history of medical jurisprudence in the nineteenth century. Instead, that initial malpractice crisis must be seen in and considered part of a much larger context of mounting problems for physicians involved with legal processes in the United States between 1840 and 1860.[53] But there is no question that the rise of medical malpractice dealt legal medicine a heavy blow, a blow that still staggers American professionals today;

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51. De Ville, *Medical Malpractice*, pp. 373–378 and 399–402. The Medical and Surgical Society of Baltimore was a good example of a local medical association that pledged its members to mutual defense in court: *Maryland Medical Journal*, 1879, 6(2):135–136. An excellent example of a local medical society responding effectively to a malpractice threat in San Francisco in 1885 is chronicled in Neil Larry Shumsky, Paul Knox, and James Bohland, " 'All For One and One For All': Medical Professionalization in San Francisco, 1850–1900," unpublished paper kindly supplied by the authors.

52. The reverse, according to Paul Starr, was also true by 1900: consolidation helped stamp out some of the most professionally damaging aspects of the early malpractice crisis. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), p. 111.

53. The author is working on a full study of medical jurisprudence in the United States through 1900, which will be published in 1993 by Oxford University Press. This article is taken from a chapter of that book.

and there is no question that it had a profound impact upon the long-term development of law and medicine in the United States.

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Revolt Against Quarantine: Community Responses to the 1916 Polio Epidemic, Oyster Bay, New York[1]

GUENTER B. RISSE

> The attempts at quarantine practiced the past summer were so incomplete, especially in many country towns, so lacking in uniformity, so changeable and erratic, that the public lost confidence in them. Hence the cooperation of the public was lost .... In this the local boards were more or less influenced in their action by hysterical groups of citizens and lay committees more governed by panic than reason.[2]

The establishment and enforcement of public health regulations designed to cope with epidemic disease has created tensions and conflicts since the Renaissance. Charged with the enforcement of cleaning up campaigns and quarantines, officials are pitted against a fearful and suspicious public. Instead of acquiescence, public health regulations have often elicited strong resistance from the very people that they are designed to protect. As historians interested in health matters began to wrestle with the issues of authority, power, and control, public health developments came to be seen as the result of complex negotiations and struggles involving all parties in society.[3] This has been recently demonstrated by the spectrum of responses to AIDS, a phenomenon that stimulates the examination of past epidemics.[4]

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1. This paper constitutes an expanded version of the Samuel X Radbill Lecture of the Section on Medical History given at the College of Physicians of Philadelphia on 17 October 1990. I would like to express my appreciation to all of the persons who helped me with my research, especially Richard A. Winsche at the Nassau County Museum Reference Library, Anthony M. Brescia from the Nassau Community College, Dorothy Moore at the Oyster Bay-East Norwich Public Library, and William P. Gorman at the New York State Archives for their kind assistance in locating sources for this study. Both Ruth Schwartz Cowan and Naomi Rogers provided valuable suggestions. Special thanks go to my assistants Rebecca Ratcliff and Andrea Richardson.

2. E. H. Bartley, "Clinical Experiences with Poliomyelitis," *Long Island Medical Journal,* 1916, *10*:459.

3. Charles E. Rosenberg, "Disease in History: Frames and Framers," *Milbank Quarterly,* 1989, *67*(supplement 1):1–15.

4. For an overview, consult the various contributions in Elizabeth Fee and Daniel Fox, eds., *AIDS: The Burdens of History* (Berkeley, Calif.: University of California Press, 1988).

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This paper chronicles and analyzes events surrounding the 1916 epidemic of polio in the village and township of Oyster Bay, New York, which culminated in a little publicized citizens' revolt against contemporary public health measures. The town's residents paid dearly for their contact with the disease. In proportion to its population, the township recorded one of the highest incidences of polio in the entire nation.[5] To understand better the multiple forces shaping public policy, an attempt has been made to place this episode within its unique cultural, scientific, and economic contexts. The emergence of this frightful "new" disease of infantile paralysis in the early twentieth century created horror and panic. Its predilection for young children caused families to pack up and flee from affected cities and towns to escape the scourge.[6] As with AIDS in the early years after its appearance, the medical profession was divided about the causes of polio, and about its transmission, treatment, and prevention. While this study represents the examination of a single epidemic in a specific geographical location, it exposes some of the dilemmas faced in America by the new, bacteriologically-informed public health.

The Coming of Polio

By the early 1900s, Nassau County on Long Island was booming, especially the North Shore communities recently linked to New York City by railroad and steamship. While large estates and farms continued to give the "Gold Coast" its traditional prestige, cottages, boarding houses, and hotels now promised a host of recreational opportunities for the average weary city dweller.[7] Among the more

5. "It has been the worst epidemic of any kind that has ever afflicted Long Island." F. Overton, "The Control of Poliomyelitis on Long Island," *Long Island Medical Journal,* 1916, *10*:445. See also John R. Paul, "The Epidemic of 1916," in *A History of Poliomyelitis* (New Haven, Conn.: Yale University Press, 1971), chap. 15, pp. 148–160. For a contemporary account, see Haven Emerson, "The Recent Epidemic of Infantile Paralysis," *Bulletin of the Johns Hopkins Hospital,* 1917, *28*:131–136 and his more extensive *A Monograph on the Epidemic of Poliomyelitis (Infantile Paralysis) in New York City in 1916* (New York: New York Health Department, 1917).

6. For a similar study of another community, see Stuart S. Galishoff, "Newark and the Great Polio Epidemic of 1916," *New Jersey History,* 1976, *94*:101–111. For further work on polio in New York, Philadelphia, and Newark in a broader context, see Naomi Rogers, *Dirt and Disease: Polio Before F.D.R.* (New Brunswick, N.J.: Rutgers University Press, 1992), forthcoming.

7. For background, consult Edward J. Smits, *Nassau, Suburbia USA* (Garden City, N.Y.: Doubleday, 1974).

Figure 1.
Courtesy of the Long Island Studies Institute, Hofstra University.

prominent resorts was the village of Oyster Bay, seat of the summer White House during the presidency of Theodore Roosevelt, who spent time at his retreat on Sagamore Hill. Tourism, and, for several years, the presence of presidential staff members and numerous newspaper reporters[8] more than compensated for the marked decline of Oyster Bay's prominence as a Long Island shellfishery (see Fig. 1). Its rich oyster and clam beds had been progressively contam-

8. An editorial in the Democratic paper the *Oyster Bay Guardian* (hereafter *O.B.G.*) of 28 April 1916 questioned the value of Roosevelt's periodic utterances to the press, insisting that the ex-Republican president was now just a plain citizen "whose dictum must not be taken as the law of reason or as absolute."

inated by the steady influx of untreated sewage into the bay.[9] The village acquired some notoriety when the Irish cook, later known as "Typhoid Mary," came to the attention of epidemiologists after six members of a single household contracted the disease in 1906.[10]

A health survey conducted in Oyster Bay during early 1916 identified the lack of a proper sewer system as a major sanitary problem. Most privy vaults and sewers from the larger estates emptied directly into the bay. This remained a sensitive issue, since the year-round population of close to five thousand people was reluctant to approve more taxes for expenditures involving public health. An earlier outbreak of diphtheria at neighboring Glen Cove had prompted state health officials to screen suspected carriers and isolate some of them; such measures were characterized by the local press as part of an unnecessary health scare deemed "adverse to the welfare of townspeople."[11] A climate of suspicion, and disregard of all sanitary advice thwarted the activities of the township's health officer, William J. Burns, a Bellevue graduate and prominent practitioner residing at Sea Cliff.[12] Burns seemed powerless to enforce local health ordinances, and his demands that violators be prosecuted fell on deaf ears at meetings of the town council.[13]

After cases of diphtheria were reported in mid-April 1916 among Polish and Italian immigrants in a new village, Forest Park, the authorities continued to express their reluctance to spend additional funds for hiring quarantine watchmen. This would have meant higher taxes, perhaps affordable by wealthy summer visitors but disagreeable to Oyster Bay's permanent residents of modest means.[14] Late in May, Burns completed his presentation of the sanitary survey, which pointed out that the very survival of the

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9. See the editorial in *O.B.G.*, 26 May 1916. Oyster Bay's main source of revenue, hundreds of thousands of bushels of oysters, was being contaminated by the sewage. The author commenting on these conditions suggested that it was time for action. "Where is the Moses who will lead the hosts out of the wilderness?" he asked.

10. G. A. Soper," The Work of a Chronic Typhoid Germ Distributor," *JAMA*, 1907, *48*:2019–2022.

11. *O.B.G.*, 3 December 1915.

12. For biographical information on Burns, see William S. Pelletreau, *A History of Long Island* (New York: Lewis, 1903), *3*:98–99.

13. "We have not as yet, unfortunately, reached the stage where we release our money *pro bono publico* unless we see the greatest benefit for ourselves." *O.B.G.*, 31 December 1915.

14. An editorial in *O.B.G.*, 14 January 1916, titled "The Health Scare," had already seriously questioned the reason for a quarantine and the expenses associated with it.

village and its oysters was at stake if pollution continued. The report was turned over to Justice Duvall, one of the town council members, but there was no further discussion concerning the sewer. By early June, the local press also strongly opposed a plan to establish a county tuberculosis sanitarium in Oyster Bay on the grounds that it was not needed.[15]

Less than a week later, on 6 June, the first victims of polio were reported from a densely populated section of Brooklyn housing Italian immigrants.[16] The disease had been rare before 1907, when it killed more than 2,500 persons in Brooklyn, but thereafter epidemics began to break out in many parts of the United States with greater frequency each summer. Between 1910 and 1915, thirty thousand cases of polio were reported throughout the country, causing about five thousand deaths.[17] The new outbreak prompted health officer Burns in Oyster Bay to press again for the prosecution of violators of local sanitary ordinances. This was appropriate, since health authorities responding to polio in New York City had adopted a number of measures historically employed to deal with epidemic disease: cleaning up the environment and the isolation of suspected cases.[18] Focused on dirt and dust, the epidemiological model underlying these measures was based on disease-bringing miasma theories. It also postulated that the biting stable fly was the necessary carrier of the contagion, and thus explained the apparent random spread of polio across both class and geographical boundaries.[19] Under the leadership of Haven Emerson, a former prac-

15. *O.B.G.*, 2 June 1916. "Absolute needlessness" was the newspaper's verdict.

16. For an overview of the public reaction in this epidemic, see Guenter B. Risse, "Epidemic and History: Ecological Perspectives and Social Responses," in Fee and Fox, eds., *AIDS: The Burdens of History*, pp. 33–66, and Rogers, *Dirt and Disease*.

17. Saul Benison, "The Enigma of Poliomyelitis: 1910," in *Freedom and Reform: Essays in Honor of Henry Steele Commager*, ed. H. M. Hyman and L. W. Levy (New York: Harper & Row, 1967), pp. 228–254.

18. A letter to this effect was received from the New York State Health Department. See Minutes, Oyster Bay town council meeting, 19 June 1916, Oyster Bay Town Hall, Long Island, New York. See also Haven Emerson, "Some Practical Considerations in the Administrative Control of Epidemic Poliomyelitis," *American Journal of Medical Science*, 1917, *153*:160–178, and by the same author "The Responsibilities of the Department of Health of the City of New York," *Long Island Medical Journal*, 1916, *10*:261–266.

19. This hypothesis was based on findings from a number of animal experiments. Consult Naomi Rogers, "Dirt, Flies, and Immigrants: Explaining the Epidemiology of Poliomyelitis, 1900–1916," *Journal of the History of Medicine*, 1989, *44*:489–505. Further details are in Naomi Rogers, "Screen the Baby, Swat the Fly: Polio in the Northeastern United States, 1916" (Ph.D. dissertation, University of

titioner familiar with cholera, New York City's health department commenced a vigorous cleaning campaign, daily dumping up to four million gallons of water on the streets.[20]

Such a traditional public health approach, based on outdated theories of disease, exposed the persistent gulf between the implementation of health policies and the new bacteriological revolution. Since 1909, bacteriologists working within the new scientific paradigm had postulated that poliomyelitis was caused by a submicroscopic microorganism transmitted by droplets in the air. Organisms entered the human body through the nose, travelled along the olfactory nerves to the brain and eventually entered the spinal cord. This hypothesis was primarily defended by Simon Flexner, the director of the Rockefeller Institute of Medical Research in New York, on the basis of experimental work performed on monkeys that were serially infected.[21] While seeing the etiology of polio similarly in bacteriological terms, clinicians were concerned about the discrepancies between the clinical picture and Flexner's model. Thus, they sought to expand the pathological model in accordance with their own observations. The mode of infection appeared complex. Most adults displayed specific immunities to the disease that suggested widespread contagion, while there were many healthy carriers alongside numerous victims who suffered mild, non-paralytic forms.[22]

The sanitation debate in Oyster Bay continued in view of the polio epidemic now raging in New York City. In June, the local newspaper complained that the expanding population was "largely composed of people who have been unused to paying regard to sanitary methods of any kind" — a reference to immigrants from Southern and Eastern Europe. Burns was portrayed as "overzealous" in his demands for improved sanitation, and his efforts were distrusted and linked to previous demands for a salary increase.[23]

Pennsylvania, 1986), and her forthcoming book. For a contemporary source, see W. H. Frost, "Poliomyelitis (Infantile Paralysis). What is Known of its Causes and Modes of Transmission," *Public Health Reports,* 1916, *31*:1817–1833.

20. *New York Times,* 10 July 1916.

21. Saul Benison, "Speculation and Experimentation in Early Poliomyelitis Research," *Clio Medica,* 1975, *10*:1–22.

22. Simon Flexner, "The Nature, Manner of Conveyance, and Means of Prevention of Infantile Paralysis," *JAMA,* 1916, 67:279–283. For a near contemporary view of this institution, see H. T. Wade, "The Rockefeller Institute for Medical Research," *The American Review of Reviews,* 1909, *39*:183–191.

23. See *O.B.G.,* 30 June 1916. Burns was paid $166.66 per month.

In view of polio's presumed spread by contact with victims, convalescents, and carriers, the New York State board of health requested that local officials institute a system of immediate reporting and prompt isolation. This appeal was made just as an exodus of parents and their children from New York City into the surrounding villages and towns began. While some families were merely beginning their customary summer vacations, others left the city in haste to escape the epidemic and a possible quarantine. Fearful arrivals in Long Island encountered high rents for rooms in lodges, hotels, cottages, and boarding houses. Burns responded by selecting a building in the Orchard neighborhood of Glen Cove to function as a possible quarantine hospital.

On 7 July, the first official case of polio was reported from Glen Cove in the Oyster Bay township.[24] Prior to the onset of symptoms, the small girl had visited Sea Cliff. This prompted the local health board there to demand that owners of rental premises report all newcomers to the police upon their arrival, so that nurses could periodically visit families with children and report those suspected of suffering from polio to the health authorities. New arrivals were generally visited every other day for at least 10 days, with all suspicious cases reported to the health officer.[25] The perceived danger became even greater as four additional children, three of them also residing in Glen Cove, were reported with polio on 10 and 12 July. Three of the victims were Italian, the other was Polish.

After a "more or less acrimonious" discussion on 10 July, the Oyster Bay town council adopted a resolution forbidding all children under the age of 16 to assemble in public places, including camps, picnics, theaters, and Sunday schools. Burns's request at the meeting to hire additional nurses, however, was tabled amid criticism from the presiding supervisor, James H. Cocks. Debate began concerning the health officer's demand to outfit a quarantine hospi-

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24. This information was acquired from the actual reporting cards signed by health officer Burns and obtained from the New York State Archives, Albany, New York. The data does not contain death certificates, thus failing to reveal the true mortality rate. There are slight discrepancies between the statistics obtained from the cards and the information reported in the contemporary Public Health Reports. All statistical statements made throughout the paper, however, are based on the reporting cards.

25. See, for example, minutes of 17 July 1916 meeting in Sea Cliff of the local board of health. Between 9–16 July, two nurses examined 219 children for a total of 519 examinations, but no cases of polio were found. This material was provided by Anthony M. Brescia from the village archives.

tal; others were in favor of allowing all suspected polio victims to remain in their homes.[26] Burns, in fact, had already removed the first polio suspects to the "Orchard." For the duration of the polio epidemic, Burns and Cocks remained at odds about all public health measures imposed by the state. Cocks repeatedly questioned the scientific basis for the quarantine regulations arguing that physicians seemed divided about the cause and spread of polio.

Matters became more complicated after 14 July, when New York City's health department began issuing health certificates to travelers, especially children, who submitted to a medical examination or could prove that they lived in disease-free residences. New York City's Association for Improving Conditions of the Poor suggested that "if the kiddies are not in the county or at shore, get them there if you can," and towns such as Oyster Bay braced themselves for the onslaught of city refugees brandishing certificates.[27] At a board meeting a week later, Burns reported 16 cases of polio in the township, a third of those afflicted were Italian; one resided in the village of Oyster Bay. Five deaths resulted. One additional case, a two-year-old Polish boy, was transferred to the isolation facility in Glen Cove. At one point, Burns accused Cocks of being a carrier since the supervisor had provided a car ride to a child later detained and suspected of having the disease.

Such revelations prompted the town council to approve a flurry of measures including a renewed ban on all visitors without health certificates issued at the point of embarkation, and a two-week quarantine for all children under the age of 16 living in the township including returning residents (see Fig. 2). Inspectors were posted at railroad stations in Hicksville, Glen Cove, and Oyster Bay to enforce these measures. Burns expressed reservations about the implementation of local "house arrests" or home quarantine of children given the conditions of extreme crowding in a number of tenements near the railroad station. Burns was severely criticized for failing to sign 50 official complaints against sanitation violators so that they could be prosecuted.[28]

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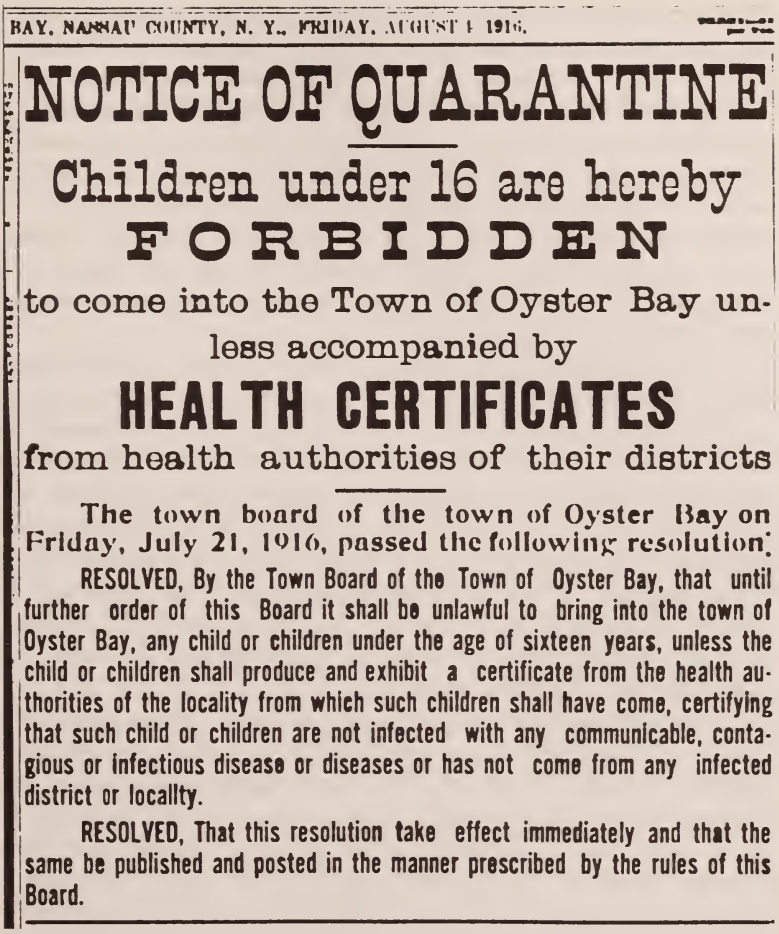
26. Minutes, Oyster Bay town council meeting, 10 July 1916. This documentation is available at the Oyster Bay Town Hall.

27. Details about the quarantine around New York City can be found in *Survey,* 29 July and 5 August 1916. Within one week, more than five thousand health certificates were issued by the New York City authorities.

28. Minutes, Oyster Bay town council meeting, 21 July 1916. See also *O.B.G.,* 21 July 1916.



BAY, NASSAU COUNTY, N. Y., FRIDAY, AUGUST 4 1916.

NOTICE OF QUARANTINE

Children under 16 are hereby FORBIDDEN

to come into the Town of Oyster Bay unless accompanied by

HEALTH CERTIFICATES

from health authorities of their districts

The town board of the town of Oyster Bay on Friday, July 21, 1916, passed the following resolution:

RESOLVED, By the Town Board of the Town of Oyster Bay, that until further order of this Board it shall be unlawful to bring into the town of Oyster Bay, any child or children under the age of sixteen years, unless the child or children shall produce and exhibit a certificate from the health authorities of the locality from which such children shall have come, certifying that such child or children are not infected with any communicable, contagious or infectious disease or diseases or has not come from any infected district or locallty.

RESOLVED, That this resolution take effect immediately and that the same be published and posted in the manner prescribed by the rules of this Board.

Figure 2. *Oyster Bay Guardian*, 4 August 1916.
Courtesy of the Long Island Studies Institute, Hofstra University.

The Committee of 21

Three days later, on 24 July, Oyster Bay's most famous resident, Theodore Roosevelt, appeared at a scheduled town council meeting accompanied by about one hundred prominent men and women from the village. In a fiery speech, Roosevelt forcefully denounced local health officials for negligence in pursuing the cleanup, and for allowing unsanitary conditions to prevail that could facilitate the spread of the new plague, infantile paralysis. "The sign posts to

Oyster Bay are tin cans and old newspapers," he declared.[29] Under intense pressure, the council reacted by approving the establishment of a citizens' Committee of 21, empowered to conduct its own sanitary campaign. Under the leadership of John F. Bermingham, a prominent resident, the group appointed a five-member subcommittee composed of local businessmen and physicians, charging them with the task of quickly making an updated sanitary survey of the village. Two Italians, Joseph De Pasquale and Joseph Diordano, were also appointed, ostensibly "in order that they be taught that cleanliness and order was for their good and was their cause as well as the cause of the Americans."[30]

The Committee of 21 wasted no time in making its own inspections. Since Oyster Bay lacked a dump, garbage was piled high in nearly every backyard. Although most houses were supposed to have cesspools, waste water emptied into a brook running through the village. The stream was clogged at many points with debris and sewage emptied into the bay. The tenement houses across from the railroad station were inhabited by poor Italians and were especially filthy. Apprised of such conditions, the town council and local authorities promptly issued warrants for the arrest of 46 residents, including a notorious slumlord, and approved procedures to haul away garbage to a new dump site.[31]

At the same time, local police officers and a constable were to patrol the roads and railway stations day and night, turning back families with children who lacked the required health certificates. A committee was also formed to replace the "Orchard" facility and find a site to house all suspected polio victims. Although somewhat irregular in its genesis and a clear legal infringement of responsibilities normally assigned to health authorities, this sudden burst of sanitary activity was applauded. As the local newspaper explained, "fear gives place to enterprise. No one can care for the interests of your village so well as its own people."[32]

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29. Minutes, Oyster Bay town council meeting, 24 July 1916.

30. Ibid. An executive committee of three members made the final selections for the Committee of 21. Among them were I. F. Barnes, Archibald Wood, and Chester W. Cole from Oyster Bay who had already reported some polio patients. Mrs. Charles Tiffany was the only female member, offering to "stamp out disease."

31. A list of violators was presented to an extraordinary meeting of the town board on 25 July. A number of tenement houses owned by Charles H. Jones, son of millionaire Oliver L. Jones, were "piled high with all sorts of refuse and dirt." On the inspecting team were two individuals previously accused by Burns as having violated sanitary laws.

32. Editorial in *O.B.G.*, 28 July 1916.

Health officer Burns, meanwhile, received an anonymous death threat for continuing to send polio suspects to Glen Cove's temporary quarantine facility located in the midst of a neighborhood populated by Italian immigrants. Anger and subsequent threats to burn down the facility resulted from the fact that a number of Italian children in Glen Cove and Oyster Bay had contracted the disease; this development was attributed to the proximity of the feared "Orchard." Frightened, owners of suitable accommodation alternatives in Glen Cove refused to allow their use as isolation facilities. A similar rejection came from the authorities in charge of Mercy Hospital at Hempstead.[33] Under attack by poor immigrants and wealthy summer residents, Burns found himself in a no-win situation: follow instructions issued by the state health authorities and risk further local antagonism, or stop reporting cases and face dismissal from the New York State Health Department.

By 1 August, more than five hundred quarantine regulations were in effect in towns and villages bordering New York City. Many other towns hired additional guards and policemen who were posted at their borders. Equipped with red flags, they stopped virtually every automobile and made careful searches for concealed children. Even the Automobile Club of America was besieged with inquiries about road blocks, as traveling members demanded alternate routes to escape such impediments. Summer camps around New York City had susceptible populations of youngsters roaming inside and outside their compounds who posed further threats and raised concerns among parents and local health officials. Many camps were closed, and their visitors sent home.[34]

In the Oyster Bay township, meanwhile, the count of reported polio cases had risen to 27, with more than a third of the victims identified in Glen Cove.[35] A dozen had been taken to the isolation hospital, all but one of Italian or Polish ancestry. Yet, only half of these children exhibited clear signs of paralysis. More than 90 per-

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33. Minutes, Oyster Bay town council meeting, 31 July 1916. This fear of extending the range of the epidemic from isolated polio cases was the reason for a protest march in Glen Cove objecting to the hospitalization of afflicted children in the local community hospital and demanding the closing of the isolation ward. Personal communication, Ruth Schwartz Cowan.

34. See daily reports in the *New York Times* during the months of July and August 1916.

35. F. Overton, however, admitted that "we missed half of our cases during July," in "Control of Poliomyelitis," p. 447.

cent of those polio suspects remaining in isolation at their homes were listed as American citizens.

The citizens' committee, now numbering 24, was authorized to conduct a cleanup campaign in Oyster Bay, and continue its inspections. Frequent meetings were held during which Roosevelt was identified as a "thought leader" whose suggestions were usually adopted without debate.[36] A fund-raising campaign was planned and a large number of letters were sent to villagers soliciting money for the local cleanup, the erection of a hospital, and the construction of a sewer. Although barely a week old, the group came under criticism by the permanent residents of Oyster Bay, because of its propensity to focus only on the "little fellows" with their backyard rubbish while ignoring the owners of larger country estates, who continued to dump their sewage into the bay with impunity. According to the local newspaper this attitude was typical of the summer residents, who were seldom seen, but were prone to organize themselves for their own self-interest.[37]

The well-heeled Oyster Bay committee focusing on waste disposal stood in stark contrast to a new Committee for the Suppression of Infantile Paralysis established in the village of Glen Cove on 6 August. This local citizens' group contained a number of permanent Italian and Polish residents who distributed information about polio in English, Italian, and Polish to the anxious population. Garbage cans were distributed free of charge, and quarantined families received replacement wages to compensate for loss of income. Five nurses were hired to carry out a house-to-house inspection.[38] The incorporated village of Sea Cliff also continued to hold regular meetings of its own board of health, under the direction of Dr. Albert M. Bell.[39]

The succeeding two weeks witnessed the height of the polio epidemic in the Oyster Bay township, with an additional 41 reported cases. Only two of the new patients were Italian, eight were

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36. *O.B.G.*, 4 August 1916.

37. Ibid.

38. The details were revealed in the *East Norwich Enterprise*, 2 September 1916.

39. *Sea Cliff News*, 5 August 1916. Albert M. Bell was the son of Charles W. Bell, the popular postmaster of the village. A graduate of Cornell University, Albert Bell had started to practice medicine in Sea Cliff in 1913. See Paul Bailey, ed. *Long Island: A History of Two Great Counties, Nassau and Suffolk*, 3 vols. (New York: Lewis Historical Publishing, 1949), 3:200–201.

listed as Polish.[40] As one editorial in the *Oyster Bay Guardian* reported, "people are reduced to a hysterical state of mind because of the spread and the lack of knowledge to prevent it."[41] Even Roosevelt seemed quite apprehensive about the "paralysis plague," especially since his grandson Richard was spending the summer with him at Sagamore Hill.[42]

Concerned about the mounting polio toll in this part of Long Island, the State of New York created a new sanitary district in Nassau County with the help of voluntary subscriptions from the adjoining towns and villages.[43] Headquartered in Roslyn, the laboratory facility was placed under the supervision of Dr. George Draper and four assistants. Hailed as the best equipped man to combat this disease, Draper was already famous for his work at the Rockefeller Hospital linked to the prestigious Institute for Medical Research in New York City. He was unquestionably the most expert American physician regarding the clinical behavior of polio.[44] The State Department of Health also instituted a house-to-house sanitary survey of the congested areas in all Nassau County villages affected by the epidemic. Inspectors were dispatched to investigate and report their findings to Albany. At the same time, new state regulations attempted to strengthen the compulsory reporting of cases, the mandatory disinfection of infected premises, and the removal of suspected polio victims to isolation hospitals. Henceforth no public funerals for victims of the disease were permitted. All violations were to carry misdemeanor charges.[45]

In Oyster Bay, supervisor Cocks reluctantly negotiated the use of new quarantine facilities at the Jones Institute in Hicksville,

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40. Similar peaks were reported for Greater New York although the epidemic was already declining in Brooklyn and Richmond. See C. H. Lavinder, "Status of Poliomyelitis in New York City," *Public Health Reports,* 1916, *31*:2407–2411 and *Public Health Reports,* 1916, *31*:2816–2820.

41. *O.B.G.,* 11 August 1916.

42. See 21 August 1916 letter to Richard Derby in *The Letters of Theodore Roosevelt,* selected and ed. by Elting E. Morison (Cambridge, Mass.: Harvard University Press, 1954), *8*:1105–1106.

43. Oyster Bay pledged the sum of $5,000 and immediately requested cash contributions of $25 and $100 from its citizens. Both Roosevelt and Bermingham contributed $25 each to the fund.

44. George Draper, a graduate from the College of Physicians and Surgeons in New York, later wrote *Acute Poliomyelitis* (Philadelphia, Pa.: Blakiston, 1917), with a foreword by Simon Flexner. For more information see Paul, *History of Poliomyelitis,* chap. 16, pp. 161–166; and George W. Corner, *A History of the Rockefeller Institute, 1901–1953* (New York: Rockefeller Institute Press, 1964).

45. Minutes, Oyster Bay town council meeting, 14 August 1916.

because of strong pressure from the Glen Cove citizenry to abandon the now infamous "Orchard,"[46] and a refusal by Sea Cliff authorities to allow the erection of a temporary structure in that village's central park. Two additional options emerged, as the Neighborhood Associations of nearby Locust Valley and Roslyn authorized the use of their own local hospital facilities.[47] The public remained opposed to isolation facilities, confused about their purpose. Were they true "pesthouses" reserved only for confirmed cases in need of medical attention or were they also observation clinics for individuals with suspicious symptomatology?[48] Since diagnosis of polio was difficult before paralytic symptoms developed, why were such "abortive cases" nevertheless taken to the same hospital and placed in contact with confirmed polio victims? Parents feared that such a measure effectively doomed children who did not have polio to contracting the disease in the institution.[49] Was it not preferable to leave suspects isolated in their own homes until a definitive diagnosis could be made? Why was this type of home quarantine allowed only for children of more affluent families? The public health measures discriminated against the poor who were often immigrants living in crowded conditions; many parents were unable to provide the necessary space and care for their offspring.[50]

A topic of frequent debate at town council meetings and in the press was the meaning and impact of the local public health mea-

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46. On 12 August, the *East Norwich Enterprise* announced that Dr. Linsly R. Williams, deputy health commissioner of the State of New York, had received a letter from Roosevelt pledging support for a campaign to outfit a new emergency hospital.

47. Minutes of regular meeting, Sea Cliff Board of Health, 21 August and 18 September 1916.

48. In his report, Overton declared that "the parents of the children who entered the hospitals were almost unanimous in praise of the institutions." Overton, "Control of Poliomyelitis," p. 448.

49. *O.B.G.*, 11 August 1916. Haven Emerson insisted that hospitalized children had fewer complications since they were under the care of a "great quartet": pediatrician, pathologist, orthopedist, and neurologist. By contrast, many of the suspects staying home were neglected. Haven Emerson, "Discussion of Symposium on Poliomyelitis," *Long Island Medical Journal*, 1916, *10*:467–468.

50. Rogers, *Dirt and Disease* will discuss the widespread ethnic and class discrimination during the 1916 epidemic. Home quarantines were routinely flaunted. One witness from New York, Janet Sommers, recounted: "I remember being quarantined. We were not allowed to go out. Food was passed into us through the window and about 11–12 [o'clock] at night my mother did sneak us out just to walk the street and back," in Neil M. Cowan and Ruth Schwartz Cowan, *Our Parents' Lives: The Americanization of Eastern European Jews* (New York: Basic Books, 1989), p. 128.

sures on Oyster Bay. Business was seriously affected as fears about polio prompted an exodus of regular summer visitors. There was a drop in sales and services, causing unemployment among the local work force. At the same time, there was a feeling that the regulations were arbitrarily enforced in the village. Some families were quarantined where no disease existed, while for others, when polio was found, quarantine rules were disregarded; parents and vendors were virtually free to come and go. The latter problems challenged the professional authority of local and state health officials in matters pertaining to the epidemic. Not only was the apparent inconsistency of most preventive measures such as hospital and home isolation challenged, but the multiple theories of disease transmission and susceptibility created widespread confusion and doubts about the value and fairness of public health laws. Local physicians tending to the sick were deemed somewhat more knowledgeable about polio than officious health bureaucrats who represented the state. In the midst of all the cleanup and quarantine rhetoric, citizens recommended traditional home remedies to fight the disease.[51]

Citizens' Revolt

On 28 August, Judge Steinert, temporary chairman of the town board, adjourned a rather tumultuous town meeting in Oyster Bay. During that session, reports about the progress of the polio epidemic presented by health officer Burns and a state health department official had been frequently interrupted and criticized by an unruly crowd. The total count had reached one hundred cases in the township; 73 had occurred during the month of August. Part of the mounting anger and frustration stemmed from the fact that the toll from the disease continued to rise. Another reason was a recent episode in which two health officers and four deputy sheriffs had forcibly removed a sick child from its father to take it to the quarantine hospital.[52] As the meeting came to an end, a group of about 160 local residents, crowded in the room, took over. Led by J.

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51. Editorial, *O.B.G.*, 25 August 1916. A reader signing his letter as "X Ray," delivered a blistering attack on the medical profession, blaming physicians for the prevailing state of hysteria in the village of Oyster Bay.

52. Unless otherwise stated, quoted material regarding discussions and events at the 28 August town council meeting is from the minutes of the Oyster Bay town council meeting, 28 August 1916.

Franklyn Underhill of Glen Cove[53] and Henry Montague Bennett from Oyster Bay,[54] this new citizen's group quickly established its own sanitary committee charged with drafting new rules to manage the polio epidemic. Foremost among them was the demand to repeal the regulation allowing the removal of suspected children to an isolation hospital without parental consent.

The lengthy document drafted by the followers of Underhill and Bennett highlights the tensions between popular and scientific views of polio, exacerbated by the chasm between laboratory and clinical models of disease. Oyster Bay citizens objected vehemently to the public health measures ostensibly instituted to protect them. The medical profession, including practitioners and medical scientists, was generally accused of creating a state of "frenzy and terror" by providing confusing information about "mysterious germs or miasmas." Critics suggested that these theories were designed more to buttress their fame, power, and "greed for gold" than to help sick people crippled by the disease.[55] In this connection, repeated diagnostic lumbar punctures came under special attack as causing additional cases of paralysis.[56] Contemporary bacteriological research was severely criticized, especially activities sponsored by endowments from philanthropists such as Rockefeller and Carnegie that were "actuated by a desire to return a small measure of good for the millions which they have extorted from the common people."[57] At the same time, the authors reiterated their respect for "those great minds among physicians and surgeons" whose devotion to mankind had brought so "many wonders in science and

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53. J. Franklyn Underhill belonged to a prominent Long Island family. See Josephine C. Frost, ed., *Underhill Genealogy* (Underhill Society of America, 1932), 3:849.

54. Henry M. Bennett was a friend of former president Roosevelt and a republican boss in Nassau County. Three months later, as he planned to become a candidate for supervisor from the Oyster Bay township, he was accused of having accepted a bribe to influence the vote of a juror in a lawsuit before the State Supreme Court. Bennett was arrested, then convicted of attempted bribery, and sentenced to five years in Sing Sing Prison. *New York Times*, 22 November 1916 and 24 June 1917.

55. "The crippling and maiming of future generations is lost sight of in the greed for gold and the lust for political power."

56. Dr. George Draper initiated diagnostic spinal punctures on 31 July. They were performed in doubtful cases without paralytic symptoms. During the middle of August, the additional diagnosticians from the State Health Department were performing 30 or more procedures per day. See Overton, "Control of Poliomyelitis," p. 446.

57. Minutes, Oyster Bay town council meeting, 28 August 1916.

innumerable blessings to the world."[58] Spared from criticism was the family doctor "whose trying ordeals, patience, kindliness, and comforting counsel have endeared him and given him a permanent, abiding place in the hearts of all."[59]

Public health officials were also heavily censured, with a resolution declaring that "both profane and modern history are replete with the medico politico barbarism which we are now experiencing, as anyone who reads the history of quarantine must understand and acknowledge."[60] The "hysterical inconsistencies of the present quarantine" were highlighted, including the "brutal removal" of children from their parents and the "alarmist reports of health officers." The frequent use of statistics to demonstrate the magnitude of the epidemic was judged as self-serving "to maintain the quota of patients and medical staffs at the improvised hospitals."[61] There were bitter complaints about using tax funds and voluntary donations to support public health activities. It was thought that such financing perpetuated bureaucratic organizations while ensuring seasonal visitations by an epidemic disease "which the skillful publicity man of these public parasites can invent to compel continued contributions."[62]

Indirectly, the Roosevelt Committee was also rebuked. Conducting inspections, hiring watchmen, and obstructing highways were deemed to be illegal actions, "detrimental of every business interest as well as to the welfare of the community in general."[63] Because of his "great heart and love of mankind," Oyster Bay's leading citizen, former President Roosevelt, was portrayed as being merely the tool of a group of misguided locals, eager to emulate the medical profession "in taking a leading part in scaring those to death who are not already infected with the money-grabbing incubus of the medical profession."[64]

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58. Ibid. See also Saul Benison, "Poliomyelitis and the Rockefeller Institute: Social Effects and Institutional Response," *Journal of the History of Medicine,* 1974, 29:74–93.

59. Minutes, Oyster Bay town council meeting, 28 August 1916.

60. Ibid. "Inasmuch as our people have contributed so generously from their funds and sympathy, the State Board of Health and its satellites have been able to establish themselves in the wealthy section, and so long as funds are readily forthcoming and the taxpayers uncomplainingly shoulder their burdens, we can be expected to be visited each season by plague."

61. Ibid.

62. Ibid.

63. Ibid.

64. Ibid.

Finally, the Bennett group, "responsible for families of children of susceptible age," formally expressed its sympathy with those who had actually been afflicted by the disease. The epidemic was said to be coming to an end thanks to the "visitation of Jack Frost." It was necessary to effect a "discharge of the medical maniacs, the resumption of local business, the recall and restoring to confidence of our easily scared summer residents, and the application of common horse sense to the co-called epidemic with which this and other communities have been afflicted."[65] To this effect, the group lobbied for highway watchmen to be withdrawn. First and foremost they called for the repeal of local ordinances ordering mothers to surrender children suspected of harboring polio to the health authorities for isolation. In the view of the committee, it excited mothers "to frenzy and terror," and forced them to hide "stricken children rather than suffer them to be seized and dragged away."[66] If these recommendations were not implemented, the group threatened to petition the governor and request the removal of the local health officer as well as all local authorities opposed to the recommendations.

Not surprisingly, an editorial in the *Brooklyn Eagle* on 29 August expressed "universal sympathy" with the resolutions adopted by the Bennett committee in Oyster Bay.[67] Another supportive editorial under the banner "Oyster Bay Rises in Majesty" appeared in the *New York Times*. Yet, as the editors also pointed out, polio was communicated by contact with children suffering from the disease and their isolation was absolutely necessary. As an aside, the *Times* writer wondered about the reaction of the village's elder statesman and whether he would forcefully reply to the insinuations since "he does not consider himself a naive or unsophisticated person."[68] The *Oyster Bay Guardian*, for its part, in commenting on the sprouting of citizens' committees, indicated that "hysteria

65. Ibid.

66. Ibid.

67. Editorial, *Brooklyn Eagle*, 29 August 1916. However, the author of this article also declared that "this is a time when patience and moderation are needed among parents and when patience and conciliatory ways are almost as much needed among physicians as professional skill." See also *New York Times*, 29 August 1916. The headline in this paper read "Townsmen Blame the Corruption of Men and Microbes by Rockefeller Millions."

68. "The Colonel is likely to make remarks as a result of having been accused thus of gullibility, and when he has an elevation either of temperature or of temper, noises audible for long distances are usually heard coming from his direction." *New York Times*, 29 August 1916.

seems to have taken possession of a large number of people."[69] This was understandable, given the unpredictable spread of polio even among the well-to-do. Despite Simon Flexner's experimental work, the true sources of infection and transmission of polio were still in doubt, thus the ineffectiveness of public health measures. These remarks were echoed by another local newspaper, the *Sea Cliff News,* which also complained about the "autocratic and czar-like methods" of the health department.[70]

On 1 September, members of the Bennett committee attended the town council meeting and requested the repeal of all quarantine measures, especially in view of the fact that the epidemic was abating and the situation in the village was less critical than during previous months. Judge Steinert categorized the reform-minded group as troublemakers and "rowdies." This characterization angered Colonel Bennett and led to a sharp exchange between the two men which ended with Bennett being ejected from the room and the abrupt adjournment of the meeting.[71] Thwarted in their efforts to procure official sanction for their resolutions, the Bennett forces nevertheless claimed a small victory. The Roosevelt committee agreed to dismiss the visiting village physician, William T. Jenkins, who was a former health officer for the Port of New York, together with five watchmen, ostensibly because of the waning of the epidemic.

Three days later, on 4 September, a large crowd attended the meeting of the Oyster Bay town council. Six new cases of polio had been reported. The session was later described as a genuinely democratic town meeting attended by businessmen, clergy, physicians, workmen, and parents of children affected by the public health regulations. After some routine matters, the session turned into a public hearing on the disputed health-related issues. The previously drafted resolutions of his committee were read and officially placed on file, and Colonel Bennett then took to the floor, acting "after the manner of a schooled lawyer."[72] Several contemporary articles and pamphlets on polio written by prominent physicians were read and entered into the record as evidence. The printed

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69. *O.B.G.,* 1 September 1916.

70. *Sea Cliff News,* 2 September 1916.

71. "Pandemonium at Board Meeting," *O.B.G.,* 1 September 1916. See also, Minutes, Oyster Bay town council meeting, 1 September 1916.

72. "People Have a Say: All Classes Appear before Board of Health," *O.B.G.,* 8 September 1916.

word was supplemented with letters from individual practitioners and members of medical organizations. Bennett's point was that, grave as it was, the polio problem could have been managed far better with less publicity and less participation by prominent medical men who were protective of their professional reputations. The epidemic had been exaggerated by medical "propagandists," thus creating a climate of fear and panic.[73]

As expected, Bennett was equally critical of the public health officials, especially of the forcible removal of children to the isolation hospital. Reading signed statements from various Oyster Bay residents, including two Polish fathers, Bennett vividly emphasized the predicament of such deprived parents, often immigrants, who were not informed about the progress of their offspring in the "pesthouse" and were not allowed to visit them. Seventeen additional Polish children had been reported as suffering from polio during the month of August, half of them living in the "Pine Hollow" section of the village. Nearly two-thirds of the children, many of them infants, were summarily sent to the isolation facility at Hicksville.[74] For those victims remaining in their homes, officials placed polio signs at the doors or in house windows in a somewhat arbitrary fashion, even in homes where practitioners who had examined the suspected children failed to make a definitive diagnosis of infantile paralysis.[75]

At this point in the discussion, both health officer Burns and Dr. George Draper from the state sanitary office at Roslyn requested to be heard. As Haven Emerson had done in New York City, Burns tried to reassure the audience that conditions at the isolation hospital were excellent, and that children were properly cared for in such institutions. However, he insisted that the six-week isolation period for all victims was necessary to prevent further contagion. Draper, for his part, was somewhat stumped by the argument from an Oyster Bay resident who found it absurd that mothers were allowed to visit their recovering children in the isolation hospital, and could

73. Those in charge of the public health campaign, by contrast, were proud of their educational efforts and the distribution of thousands of circulars to health boards as well as the placing of advertisements in newspapers. See Overton, "Control of Poliomyelitis," p. 448.

74. Data from the polio reporting cards, New York State Archives, Albany, New York.

75. According to one author, "very few physicians on Long Island were prepared to diagnose a case unless a paralysis was so evident that the mothers themselves recognized the case," Overton, "Control of Poliomyelitis," p. 446.

come and go as they pleased. The mother of one quarantined child testified that the institution allowed her to assume some cleaning duties while visiting. These apparent inconsistencies in what was believed to be a strict quarantine made little sense to laypersons. Suggestions were made that conditions at the isolation hospital be investigated by an impartial medical officer.

As the meeting continued, Draper launched into a vigorous defense of the medical profession, including those practitioners devoted to public health. In his view they followed strict guidelines established by the state health department. He accused Bennett of "grossly slandering" physicians, and then launched into a long, technical discussion of the possible causes and oral transmission mechanisms of polio, a diatribe in which no new information was presented. Draper's comments caused the audience to make the criticism that if the oral transmission theory was correct, physicians were mostly responsible for the epidemic, as they carried the disease from house to house during their professional visits. While forced to acknowledge such a possibility, Draper argued that practitioners usually kept out of the "cough or speech line" of the patient during their examinations. Undaunted by this argument, Bennett concluded his lengthy presentation by returning to the central charge that local and state health officials had deliberately terrified the population to justify their professional standing. The hearing ended inconclusively without the town council taking any official action.[76]

The next day, however, the meeting resumed under the chairmanship of supervisor Cocks, who had been ill when the Bennett committee first presented its demands. Although the epidemic was still in progress, the Oyster Bay council voted to lift the ban forbidding children under the age of 16 to attend camp meetings, picnics, motion picture shows, and other public gatherings. Moreover, in conformity with the actions of the Roosevelt committee, it laid off all highway watchmen and sanitary inspectors hired to enforce the quarantine, *de facto* lifting it. However, a motion by Cocks to rescind that section of the health code mandating isolation of suspected polio cases was defeated by his colleagues on the board, Steinert and Duvall, in spite of a petition to repeal it signed by nearly three hundred residents. The ensuing turmoil featured the Cocks and Bennett partisans on one side, pitted against justices Steinert and Duvall, town clerk Weeks, and the public health offi-

76. Minutes, Oyster Bay town council meeting, 4 September 1916.

cials. The meeting was quickly adjourned. Cocks insisted that since the quarantine regulations were unconstitutional, they did not require an annulment. He offered to provide free legal assistance to anyone wishing to challenge public health ordinances. Outside the town hall, "high health officials" (presumably Draper and his assistants) now confided to a dwindling audience that public health work in the village had indeed been mismanaged from the start, a veiled reference to health officer Burns's apparent lack of tact.[77]

The next issue of the *Oyster Bay Guardian* carried an editorial that blamed the villagers' frustration with the epidemic on the actions of public health officials. Titled "What Are We to Believe?" the article once more enumerated the three problematic issues: doubts about the authority of medical knowledge in the diagnosis of polio; lack of proper treatment; and the apparent "brutality of the quarantine." In the laity's view, common children's summer diseases were now routinely diagnosed as polio " as a matter of safety." Given the subsequent hardships of quarantine and hospitalization for the presumed victims and their families, this rather casual professional action was found unacceptable. Moreover, there was an inherent danger in spinal punctures, and in addition the negative results of laboratory spinal fluid analyses inevitably arrived too late to prevent suspected cases from being carted off to hospitals or dreaded signs being placed on doors and windows of quarantined houses.[78]

A week later on 12 September, a crowd assembled for the town council meeting "evidently expecting pyrotechnics," because rumors were circulating in the village that quarantine measures were to be reinstated. Health officer Burns reported an additional six polio cases, four of them from Glen Cove — hardly an indication that the epidemic had subsided. Responding to questions, Burns emphasized that Oyster Bay had no jurisdiction over the reporting and transfer of suspected polio cases. State health regulations could be neither modified nor repealed by local units of government. Faced with such legal barriers, and feeling uneasy because polio persisted, members of the council reluctantly tabled a proposal by the Bennett committee to revise or rescind such health rules.[79]

On 15 September, the Roosevelt committee issued its report. The document confirmed that workers were hired to remove accu-

77. Minutes, Oyster Bay town council meeting, 5 September 1916.
78. Editorial, "What Are We to Believe?" *O.B.G.*, 8 September 1916.
79. Minutes, Oyster Bay town council meeting, 12 September 1916.

mulated rubbish in the village, and six quarantine watchmen were employed to be positioned at all points of entry to the town in order to intercept visitors without health certificates. Committee members took pains to state that their activities had not been meant to usurp functions entrusted to public health officials who, in their view, had "acted with coolness and judgment." Nevertheless, to assist Burns with the identification and disposition of suspected polio cases, the group had engaged another physician and a trained nurse. Further support was provided to set up the isolation hospital in Hicksville and equip Draper's station at Roslyn. Finally, the committee also claimed to have distributed funds to quarantined households "provided such parties were found worthy and obedient to the regulations imposed." According to records, about 150 subscribers had donated a total of $5,000 with additional pledges doubling that sum of money.[80]

Epilogue

The total count of reported polio cases for September in the Oyster Bay Township was 20, with only one Italian and two Polish victims listed. The fear that immigrants were prominently involved in spreading the contagion ebbed. The feast of St. Rocco, which had been postponed since August, took place and attracted thousands of visitors to the village. The usual Columbus Day celebrations and a firemen's tournament took place without restrictions. The U.S. Public Health Service discontinued the federal inspection of travelers leaving New York City on 14 October. At the suggestion of health officer Burns, the isolation hospital was to be closed in November. As a grim reminder, two "polio clinics" or educational sessions were scheduled for late October in Glen Cove and Oyster Bay, to be attended by medical experts and parents of the victims to discuss muscular atrophy, paralytic symptoms, and other sequelae. Time-consuming and often frustrating rehabilitation efforts were discussed.[81]

The battle, however, had not ended. In a last gasp, polio returned on 30 November, striking six children in Oyster Bay, Locust

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80. "Work Done by Oyster Bay Sanitary Committee," dated 9 September 1916 in Oyster Bay. See *O.B.G.*, 15 September 1916.

81. A. Whitman, "Poliomyelitis As a Public Problem," *New York State Journal of Medicine*, 1917, *17*:259–264; see also W. Truslow, "Prevention and Correction of Deformity in Poliomyelitis," *Long Island Medical Journal*, 1916, *10*:453–455.

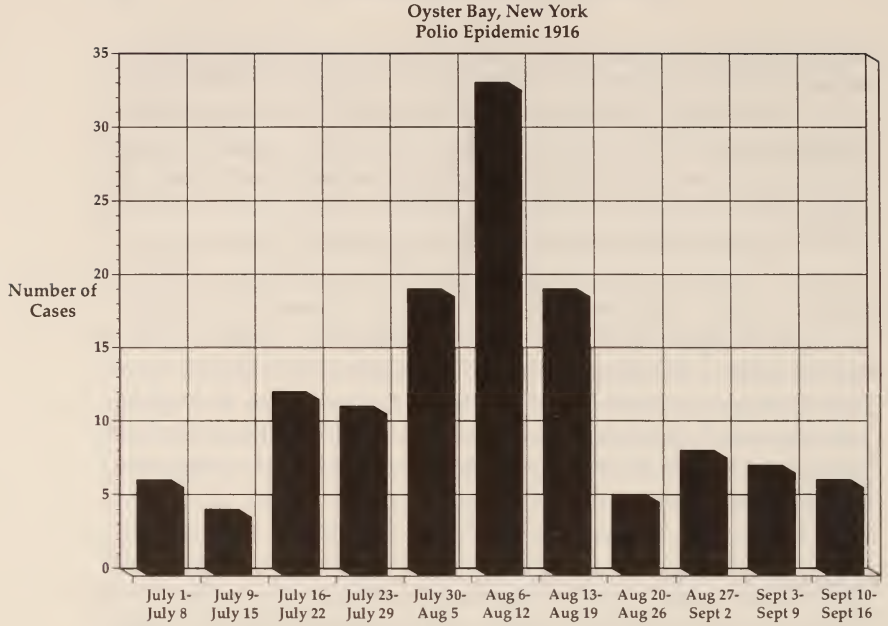

Figure 3.

Valley, and Hicksville. The final tally for the township was 130 cases, of which 63 were sent to isolation facilities.[82] The village of Oyster Bay reported 44 cases, nine per one thousand population compared with 1.6 per one thousand in New York City and 0.6 per one thousand for most cities in upstate New York.[83] For the 1916 epidemic, the total number of polio cases reported in the entire state outside of New York City was 4,214 with a mortality rate of 26 percent. Nassau County alone registered 482 with an average mortality rate of 25 percent (see Fig. 3).

We owe our knowledge of the extraordinary events in Oyster Bay to dispatches from a reporter of the *New York Times* stationed in the village during the summer of 1916. Searching for quotable statements from the inimitable former president, this journalist stumbled across a cleanup campaign launched by notable summer

82. This data was also obtained from individual reports filed with the State Health Department in Albany. Again, no deaths can be ascertained from the documentation but the mortality rate for Nassau County was estimated to be 25 percent. Twelve of the 130 cases were identified as Italians, 24 were Polish.

83. See M. Nicoll, Jr., "The Epidemic of Poliomyelitis in New York State in 1916," *New York State Medical Journal,* 1917, 17:270–274.

residents as the toll from polio mounted and the epidemic spilled from ethnic neighborhoods to the population-at-large. Even those adults who worked on estates, such as chauffeurs and gardeners, were not spared.

As it did everywhere, the polio epidemic in Oyster Bay generated many scapegoats, from Italian and Polish immigrants to public health officials. Class and ethnicity played major roles when blame for the epidemic was assigned as well as when individuals were targeted for quarantine. When the epidemic was over, Italians contributed close to 10 percent of the reported victims, the Poles more than 18 percent.[84] Cultural stereotypes were bountiful, from Italians who ostensibly needed to be taught cleanliness to become full-fledged American, to emotional Polish fathers who, as irrational obstacles to public health, needed to be restrained by police as their children were dispatched to isolation hospitals.

Economic issues were never far from the center of spirited debates. Local authorities and commercial interests in Oyster Bay wavered between permissive policies that might import disease along with tourism, and strict quarantine regulations that would cripple local business. Ironically, during that summer, both approaches would contribute to Oyster Bay's reputation as the "pest hole" of Long Island. Anxiety would prompt an exodus of summer residents, and the attendant loss of revenues and unemployment would compound the problems of the declining fisheries. There were also traditional tensions between permanent residents and well-to-do summer visitors ensconced in their lavish estates. Although the former were responsible for providing an acceptable infrastructure on which local tourism and commerce could flourish, landowners seldom cared about local needs unless their own well-being was threatened. To raise local taxes was to commit political suicide. Overwhelmed by the growing demand for more services, the township with its modest revenues simply failed to provide them, exposing the lack of such basic sanitary infrastructure as sewers and garbage dumps. Health-related expenditures ranked low on the list of local priorities — even the "niggardly" expenditure for the salary of a health officer was deemed a waste!

To a lesser degree, such issues were influenced by political considerations. Roosevelt and Bermingham represented the wealthy

84. In the United States census of 1920, Italians constituted only 3.4 percent of the population living in Nassau County; at 2.8 percent Poles made up even less.

businessmen, physicians, and landowners of the township, all of whom were staunch Republicans. Both Steinert and Duvall, nicknamed the "little judges," were also Republicans, perennially dragging their feet and failing to prosecute the rich and powerful, even when the local health officer identified them as apparent violators of sanitary laws. Duvall was later accused of issuing pistol permits without sufficiently investigating the applicants. Colonel Henry Bennett was an exception. He was the Republican political boss in Nassau County, and a friend of Roosevelt; yet Bennett was a man prone to espouse populist causes if it suited his politics and ego. Only supervisor Cocks, the chairman of the board of supervisors at the time, was a Democrat with a proven record of championing the causes of poor people.[85] During meetings of the Oyster Bay council, he frequently remained at odds with his colleagues on the board, opposing the actions of health officer Burns as autocratic and unsympathetic to the plight of the lower-class immigrants Cocks sought to protect. His actions were endorsed by Democratic newspapers such as the *Oyster Bay Guardian,* the *Sea Cliff News,* the *Glen Cove News,* and the *East Norwich Enterprise.*

Events in Oyster Bay during the summer of 1916 exposed serious cracks in the professional authority enjoyed by American doctors. The polio epidemic starkly revealed the impotence of physicians who represented the new "scientific" medicine. The Pasteurian revolution claimed to have enabled scientists to pinpoint polio's etiological agent. However, in the face of a very threatening disease with significant mortality and permanent, deforming complications that terrorized the population, physicians seemed bewildered and divided about the locus and mechanisms of polio transmission.[86] What was a "virus?" Was it really contagious? How could it be

85. James H. Cocks, originally postmaster of Glen Cove during the administration of president Grover Cleveland, served three terms as a member of the board of supervisors of the Oyster Bay Township, retiring from active politics in December 1916. He was president of the Nassau Union Bank and "the foremost Democratic leader" of the county. See obituaries in *Nassau Daily Star* and *Nassau Daily Review,* 23 October 1929. Other biographies are contained in Henry I. Hazelton, *The Boroughs of Brooklyn and Queens, Counties of Nassau and Suffolk, Long Island, New York, 1609–1924* (New York: Lewis Historical Publishing, 1925), *5*:86.

86. Overton blamed physicians for failing properly to inform the public, feeding "medical pablum" instead. Overton, "Control of Poliomyelitis," p. 447. A recent reexamination of this question can be found in N. Nathanson and J. R. Martin, "The Epidemiology of Poliomyelitis: Enigmas Surrounding Its Appearance, Epidemicity, and Disappearance," *American Journal of Epidemiology,* 1979, *110*:672–692.

transmitted? Why were so many children spared?[87] Dangerous diagnostic techniques such as spinal taps, the limited technical ability correctly to diagnose and make a prognosis, and untried as well as ineffective vaccines[88] failed to stem the natural history of the disease, thus creating widespread public skepticism and outright distrust.[89]

Epidemiological debates concerning the importance of filth, the role of flies, and healthy carriers only created more confusion. Public health campaigns mounted by local health departments both in New York City and Oyster Bay focused on the role of garbage, and were beholden to the older miasmatic paradigm that could be conveniently linked through flies with the polio microorganism. In New York, thousands of volunteers were mobilized in a war against filth. Street cleaning and removal of refuse became patriotic duties which no responsible American could ignore. Flyswatters and screens to fend off the pesky stable flies were widely distributed to the public.[90] Roosevelt and his committee targeted backyard rubbish heaps, manure pits in stables, clogged gutters, and overflowing water closets.

What appears most remarkable from the debates and the citizens' revolts at Oyster Bay was the low esteem in which the medical profession was held by the public. Physicians, especially the public health officials, were repeatedly branded as being heartless, autocratic, and incompetent. Residents of Oyster Bay, many of them recent immigrants, vigorously opposed disease control strategies that resorted to coercion without furnishing plausible reasons for the measures proposed. "Times have changed," wrote one local editorialist, "the old family physician whose entire life and skill was devoted to his neighbors and friends is rapidly becoming simply a pleasant memory."[91] In his place, a new school of physicians "making their profession a business" had emerged, and there was a feeling

87. For a review of the public's involvement with the germ theory, see Nancy Tomes, "The Private Side of Public Health: Sanitary Science, Domestic Hygiene, and the Germ Theory, 1870–1900," *Bulletin of the History of Medicine,* 1990, *64*:509–539.

88. C. W. Wells, "Immune Human Serum in the Treatment of Acute Poliomyelitis," *JAMA,* 1916, *67*:1211–1213, and Rogers, *Dirt and Disease.*

89. "There are some who say that our efforts were of no avail and that the disease burned itself out from lack of susceptible persons," Overton, "Control of Poliomyelitis," p. 446.

90. Naomi Rogers, "Germs with Legs: Flies, Disease, and the New Public Health," *Bulletin of the History of Medicine,* 1989, *63*:599–617.

91. Editorial, *Sea Cliff News,* 2 September 1916.

that high-paying customers were entitled to proper communication and explanation. "The American public will not submit to frequent insult to their intelligence. Every intelligent man and woman in the town of Oyster Bay will do his or her utmost to help stamp out any contagious disease, but they are going to insist on facts being intelligently told to them by competent authorities."[92] In a warning to future health policy makers and officials, the writer concluded: "Unless there is a material change in the methods employed by men in official positions charged with safeguarding the health of communities, the actions of the Oyster Bay citizens will be a common occurrence in other localities."[93]

For the past 10 years, American society has responded in manifold and often contradictory ways to the AIDS epidemic. These events make it imperative that we study in detail the complex web of factors involved in such reactions to mass disease. Historians have an obligation to examine past epidemics and provide new perspectives for understanding them. The story of Oyster Bay's revolt against public health measures instituted during the polio epidemic of 1916 offers a number of useful parallels, especially the ambiguity of medical science, the stigmatization of minorities, and the institution of policies driven by fear.

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92. Ibid.
93. Ibid.

A Tale of Pursuing Health Deception

JAMES HARVEY YOUNG

When one stands at my point along life's trail, he is tempted to reflect on why, long ago, he selected, or was lured into, the theme upon which he has lavished the major portion of his research and writing and lecturing hours. In my case, up to this congenial moment, that total accumulates to 6,820 hours. So indulge me, please, while during this 6,821st hour, I seek to recapture reasons that led me to begin a pursuit of the history of health deception.

My first publication that had anything to do with science came when I was in the fifth grade. The short piece appeared in a Sunday

Figure 1. Hypnotizing the chicken, Brimfield, Ill., circa 1927.
Photograph by William Harvey Young. Courtesy of Barbara Young, Baltimore, Md.

This paper was presented, in a slightly different form, as a Francis C. Wood Institute for the History of Medicine Seminar on 26 September 1991 at the College of Physicians of Philadelphia.

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School paper accompanied by this picture taken by my father (see Fig. 1). The article bore the title "How to Hypnotize a Chicken." You observe the chicken and me, the mesmerist, and my awed siblings and playmates. The paper circulated widely, even into all foreign lands to which the Congregational denomination had sent missionaries, and I received many letters from afar: China, Malaysia, Australia. This response augmented my stamp collection, bolstered my ego, and gave me an inkling of the pleasure to be derived from seeing one's words in print. Most of the mail had a testimonial flavor: "I could not believe the promise of your headline," my correspondents wrote, "but then I got a chicken and tried your method and, to my amazement, it worked at once and continued without fail." The residual impact of this correspondence may have aimed my curiosity in later years at the hundreds of testimonials in patent medicine advertising. These might be slyly remote, trafficking on the valor of a former president (see Fig. 2). Or they might grandly display one of the nation's proud patriotic symbols while citing praise from its French designer (see Fig. 3). Or they might be astoundingly current and politically correct (see Fig. 4). Pe-Ru-Na, a high-alcoholic nostrum, one House member averred, had "rejuvenated" so many members of Congress that it was certainly "the favorite Congressional drink."[1] Or they might be collected for a very small fee from the country's centenarians. To be fair, I must add that Native Americans, whom I showed as enemies a minute ago, appeared much more often in patent medicine promotion as benefactors of white men and women, giving to them in their cities the healing plants of nature found in the woods (see Fig. 5).

During my chicken-hypnotizing phase, three other experiences occurred that, I believe, may have bent the twig of my interest. During several summers I visited an uncle who was a country doctor in Iowa. I accompanied him on his rural rounds and occasionally stood by to help him in an emergency, on one occasion, for example, holding the basin while he washed away blood and sutured cuts sustained by a young couple when they wrecked their car hitting a hog in the road. About the same time, I read with great fascination Paul de Kruif's *Microbe Hunters*[2] and Sinclair Lewis's *Arrowsmith*.[3] Many years later, I was impressed at discovering how many reform-

1. James Luther Slayden of Texas in *Congressional Record*, 59th Congress, 1st Session, 22 June 1907, p. 8987.

2. Paul H. de Kruif, *Microbe Hunters* (New York: Harcourt Brace, 1926).

3. Sinclair Lewis, *Arrowsmith* (New York: Harcourt Brace, 1925).

Figure 2. General William Henry Harrison at the Battle of Tippecanoe in Indiana, 1811.

From the Warshaw Collection, Archives Center, National Museum of American History, Smithsonian Institution, Washington, D.C.

Painting of the Statue of Liberty in the Harbor of New York. Presented to M. Mariani by BARTHOLDI.

"Vin Mariani" seems to brighten and increase all our faculties; this precious wine will give me the strength to carry out certain other projects already formed, for which accept thanks from yours cordially:

Bartholdi.

Commandeur Légion d'honneur.

Figure 3. Frederic Auguste Bartholdi, designer and builder of the Statue of Liberty, praises a wine and coca nostrum that developed a large international market.

Facing title page of Mariani & Co., *Collective Testimony of the Benefit and Virtue of the Famous French Tonic Vin Mariani* (New York: Mariani & Co., 1910), in the Collections of the Library of Congress, Washington, D.C.

SUNDAY MORNING. THE MONTGOMERY ADVERTISER. JANUARY 17, 1904.

50 Members of Congress Send Letters of Endorsement To the Inventor of the Great Catarrh Remedy, Pe-ru-na.

Hon. H. H. Powers.

Congressman Powers of Vermont.

Congressman H. Henry Powers, of Vermont, writes from Morrisville, Vermont:

"Peruna I have used in my family with success. I can recommend it as as an excellent family remedy and very good for coughs, colds and catarrhal affections.

Catarrh in its various forms is rapidly becoming a national curse. An undoubted remedy has been discovered by Dr. Hartman. This remedy has been thoroughly tested during the past forty years. Peruna cures catarrh in all phases and stages. There is no remedy that can be substituted.

Hon. Irvine Dungan.

Congressman Irvine Dungan of Jackson, Ohio.

Congressman Irvine Dungan, of Jackson, Ohio, elected to the Fifty-second Congress as a Democrat, in a recent letter from Washington, D. C., says:

"I desire to join with my many friends in recommending your invaluable remedy, Peruna, to anyone in need of an invigorating tonic, and whose system is run down by catarrhal troubles. Peruna is a permanent and effective cure for catarrh and I would advise all who are afflicted with this disease to try this remarkable remedy."

IRVINE DUNGAN.

Hon. Romulus Z. Linney

Congressman Linney from North Carolina.

Congressman Romulus Z. Linney, from North Carolina, writes:

"My private secretary has been using Peruna for several weeks, and I wish to testify as to its great value and merits in cases of catarrh. My secretary had as bad a case as I ever saw, and since he has taken one bottle he seems like a different man. Before he started on Peruna his system was very much run down, and at times he could not work at all, but ever since his first bottle he has been building up. I don't think any man who is under a nervous strain should be without it. I cannot express the good it has done him."

Congressman Ogden from Louisiana.

Hon. H. W. Ogden, Congressman from Louisiana, in a letter written at Washington, D. C., says the following of Peruna, the national catarrh remedy:

"I can conscientiously recommend your peruna as a fine tonic and all-round good medicine to those who are in need of a catarrh remedy. It has been commended to me by people who have used it as a remedy particularly effective in the cure of catarrh. For those who need a good catarrh medicine I know of nothing better."

Hon. H. W. Ogden.

Congressman Smith from Illinois

Hon. George W. Smith, member of Congress, in a recent letter to the Peruna Medicine Co., says the following in regard to Peruna for catarrh.

House of Representatives, U. S., Washington, D. C.

The Peruna Medicine Co., Columbus, Ohio:

Gentlemen—I take pleasure in testifying to the merits of Peruna. I have taken one bottle for my catarrh, and I feel very much benefited. To those who are afflicted with catarrh and in need of a good tonic I take pleasure in recommending Peruna."

Resp. GEO. W. SMITH

Congressman Smith's home address is Murphysboro, Ill.

Hon. George W. Smith.

Congressman Meekison from Ohio.

Hon. David Meekison is well known not only in his own state but throughout America. He began his political career by serving four consecutive terms as mayor of the town in which he lives, Napoleon, O. He was elected to the Fifty-fifth Congress by a very large majority, and is the acknowledged leader of his party in his section of the State. In a recent letter he says:

"I have used several bottles of Peruna and feel greatly benefited thereby from my catarrh of the head. I feel encouraged to believe that if I use it a short time longer I will be able to fully eradicate the disease of many years standing." Yours truly,

DAVID MEEKISON.

Congressman Wilber of

Figure 4. Pe-Ru-Na, made in Cincinnati, was probably the largest selling patent medicine in the nation at the turn of the century.

From the *Montgomery Advertiser*, Alabama, 17 January 1904.

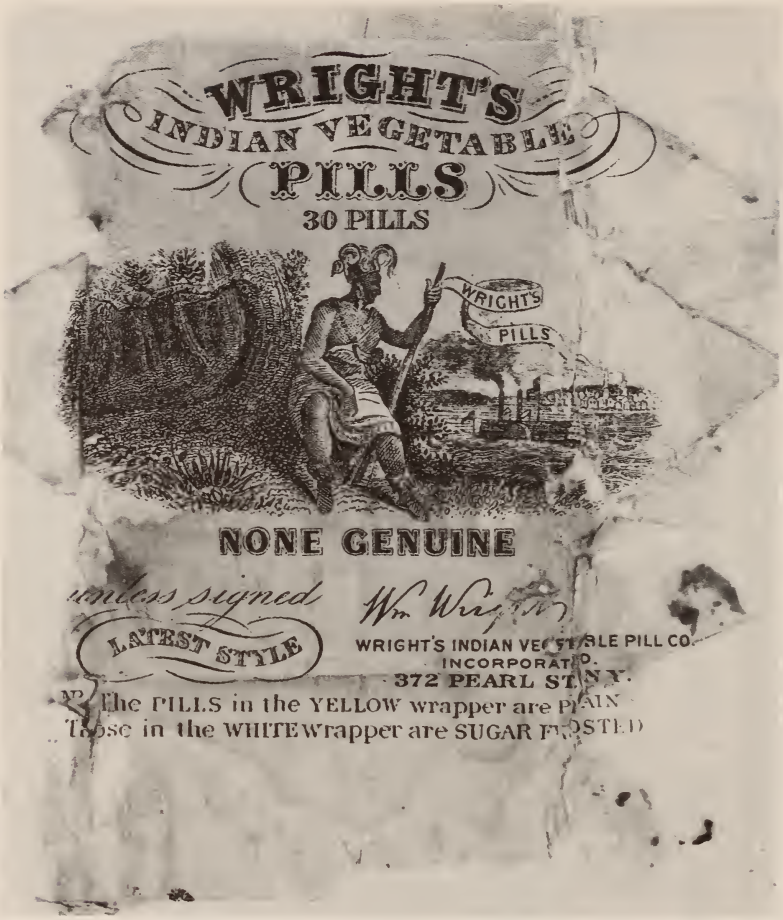

Figure 5. On this mid-nineteenth-century pill box label, white man's civilization flourishes across the river, but in the foreground the red man promises botanicals he has discovered in the forest to cure the white man's ills. From the author's collection.

ers during the Progressive period remarked in their autobiographies that reading Henry George's *Progress and Poverty* in their youth had been a powerful formative influence in their lives. I have wondered if reading *Microbe Hunters* and *Arrowsmith* may not have played a similar role for a generation of physicians. The significant linkage between de Kruif and Lewis I was not to learn until I read Charles Rosenberg's illuminating article, "Martin Arrowsmith: The

Scientist as Hero," in the *American Quarterly.*[4] The two books and my uncle influenced me, I am sure, but not toward a career in medicine; I cannot recall ever having harbored that ambition. Perhaps the chicken testimonials had already pointed me too firmly in a deviant direction, a direction bolstered by seeing a quack in action.

Itinerant medicine men were still on the move in my youth, although the traveling troupe was almost gone, the coup de grâce the lack of tires in World War II. During the second half of the nineteenth century, medicine shows of all magnitudes had traversed the nation. The young James Whitcomb Riley, for example, spent the summer of 1872 traveling in rural Indiana with eccentric Doc McCrillus of Anderson.[5] Riley painted signs for Doc's Standard Remedies on fences and barns (see Fig. 6). "His marvelous brews and concoctions," Riley asserted, "relieved every form of distress from 'The pinch of tight shoes, to a dose of the *blues*.' "

Three years later, Riley joined Dr. C. M. Townsend of Lima, Ohio, in promoting King of Coughs, Magic Oil, Cholera Balm, and Worm Candy in Indiana. Traveling in a covered wagon, Townsend's troupe, at the outskirts of a town, would arouse the population with blasts from a horn, then form a band and parade through the streets. Townsend gave afternoon and evening lectures. The versatile Riley, called the "Hoosier Wizard," would beat the bass drum, sing ballads, give readings, act in skits, and draw cartoons on a blackboard while his employer extolled the merits of his medicines. "Last night in Winchester," the poet wrote, "I made a decided sensation by making a rebus of the well-known lines from Shakespeare —

> Why let pain your pleasures spoil,
> For want of Townsend's Magic Oil?

Most small-scale medicine shows were neither so moral nor so literary.[6] This was true of the nostrum vendor whose pitch — there was no accompanying entertainment — I harkened to back in my boyhood at the bandstand of my Illinois village. To persuade people to buy his bottled liniment, he poured a dollop on one side of a

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4. Charles E. Rosenberg, "Martin Arrowsmith: The Scientist as Hero," *American Quarterly,* 1963, *15*:447–458.

5. Marcus Dickey, *The Youth of James Whitcomb Riley* (Indianapolis, Ind.: Bobbs-Merrill, 1919), pp. 105–131 and 193–215; Richard Crowder, *Those Innocent Years* (Indianapolis, Ind.: Bobbs-Merrill, 1957), pp. 57–63 and 68–72.

6. Brooks McNamara, *Step Right Up* (New York: Doubleday, 1976).

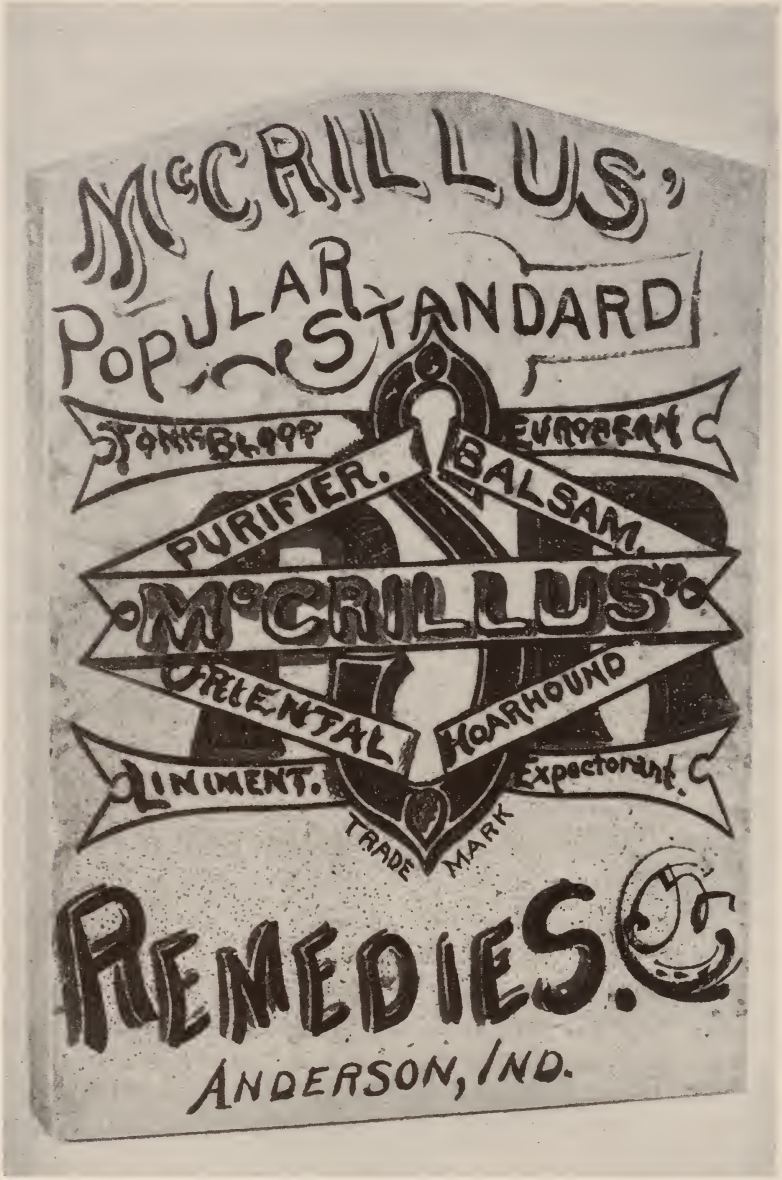

Figure 6. The Hoosier poet, James Whitcomb Riley, in his young manhood designed this Standard Remedy trademark for a traveling medicine show proprietor.

Reproduced with the permission of Macmillan Publishing Company from Marcus Dickey, *The Youth of James Whitcomb Riley* (Indianapolis, Ind.: Bobbs-Merrill, 1922, renewed 1950), facing page 121. All rights reserved.

razor strop, displaying with a grand gesture how the oily liquid passed through the thick leather, emerging as a wet stain on the other side. His marvelous formula, the pitchman proclaimed, possessing such palpable penetrating power, could, of course, speed through the human skin to ease muscular aches and pains, and, he added boldly, to heal more grievous ailments afflicting the organs inside the body. Many of my elders in the audience paid out their dollars for the liniment, but I remained dubious, sensing that the pitchman's mode of proof fell short of substantiating his broader claims. It was the purchasers who had been hypnotized.

I moved to a larger town, although small enough to have a weekly newspaper on which I worked as both printer and reporter. So when I had finished high school and college and had gone on to graduate school at the University of Illinois, I decided I wanted to use the University's exceptional collection of the state's early newspapers as source material for my history master's thesis. My adviser, Theodore Calvin Pease, was utterly non-directive. He made no suggestions to his students, requiring them to come up with and test out their own proposals for theses. I decided to study how the early newspapers were financed, but I found there was insufficient source material. Then my long latent interest in the theme of health resurfaced, and I explored the way in which the newspapers presented disease and health among the pioneering people.[7] The abundant patent medicine advertising served as the basis for my most original chapter. The clever nature of the brazen claims entranced me but did not overcome my skepticism lingering from the day I had listened to the liniment barker.

In my early years of teaching at Emory University, I turned my patent medicine chapter into two articles.[8] Then, one day in 1951, upon entering my classroom, I noticed a poster thumbtacked to a bulletin board. It announced that Louisiana state senator Dudley LeBlanc was bringing his Hadacol roadshow to Atlanta (see Fig. 7). By then nationally known, Hadacol had begun as a Cajun phenomenon, boomed by French and English testimonials praising its efficacy for arthritis, asthma, diabetes, epilepsy, gallstones, heart

7. James Harvey Young, "Disease and Patent Medicine in Southern Illinois before 1840" (M.A. thesis, University of Illinois, 1938).

8. James Harvey Young, "Patent Medicine in the Early Nineteenth Century," *South Atlantic Quarterly,* 1949, *48*:557–565, and "Patent Medicines: The Early Post-Frontier Phase," *Journal of the Illinois State Historical Society,* 1955, *46*: 254–264.

Figure 7. Dudley LeBlanc of Louisiana promoted his gigantic revival of the old-time medicine show in 1951.
From the author's collection.

trouble, high and low blood pressure, paralytic strokes, tuberculosis, and ulcers. Before reaching Atlanta, however, LeBlanc had shrunk the categorical claims for his vitamin-B-plus-iron-and-alcohol concoction and given it instead a different purported prowess suggested by Hadacol's theme song, "What Put the Pep into Grandma?" Indeed, LeBlanc hired gag writers to create stories about Hadacol's aphrodisiacal potency. These tales were told by clowns and by LeBlanc himself on stage at his revival of the old-time medicine show inflated into gargantuan proportions. The night I attended, duly buying two bottles of Hadacol to secure the box-tops for my admission fee, the show was emceed by no less a figure than Jack Dempsey. Carmen Miranda represented Hollywood, and Hank Williams and Minnie Pearl sang country music. I had talked with two of LeBlanc's advance agents before he came to town and was supposed to interview him after the evening performance. He departed, however, before it ended.

What struck me with great force about the Hadacol show was that, for all its modern flair, at heart its basic psychology in hyping a nostrum distinctly resembled that of patent medicine promotion in the early Illinois press. Here were two points on a time line that demanded tracing. I wrote a short piece on Hadacol for my university quarterly and began in earnest the research for a book.[9] Physicians and pharmacists, through the course of American history, had paid heed to proprietary nostrums, condemning their deceptions and dangers. A notable member of the College of Physicians of Philadelphia, S. Weir Mitchell, told of seeing a self-proclaimed eye doctor's sign in the lobby of a small hotel, promising that the "doctor" could restore sight to the blind by removing the offending eye, scraping its back, and restoring it to the socket. Dr. Mitchell, incognito, confronted the man. "May I ask," Mitchell said, "what anesthetic you used?" "I can hardly explain that to you," the quack replied, "you wouldn't understand; but I can tell you that it's shaped something like a spoon."[10] Few physician critics of quackery, however, placed it within a broader social and intellectual setting.

Historians had now and then considered proprietary pills and potions as one aspect of another larger theme, for example, Thomas

9. James Harvey Young, "The Hadacol Phenomenon," *Emory University Quarterly,* 1951, 7:72–86.

10. M. G. Selig, "Quacks and Quackery," *Journal of the Mount Sinai Hospital,* 1938, 4:673.

D. Clark's shrewd observations about nostrums sold in country stores and advertised in country newspapers.[11] Very little, however, had been written either by popular or academic historians in which quackery held center stage, and most of this neglected quackery's sobering features, instead focusing on the colorful, the amusing, and the bizarre. For me, too, quackery's outrageous excesses possessed a morbid fascination, and I desired to exploit them, but I mainly intended to explain the grievous impositions quackery places upon society's well-being. Thus my sense of mission in writing *The Toadstool Millionaires* and *The Medical Messiahs*.[12]

Here, besides telling my own tale, I want to suggest how narrative plays a part in my writing about quackery. This probably was a natural response to the fact that narrative has always been a fundamental ingredient in nostrum promotion. In the explosion of quackery in early modern Europe, Grete de Francesco has observed, charlatans "were far from unaware of the need of mankind for connected stories," and so they told such tales from platform or in print, "in order to make sales."[13] This tradition persisted. The product is presented as a unique all-powerful curative agent. Whence has this wonder come?[14] Did a missionary bring the secret back from the jungles of darkest Africa? Was the formula recorded in hieroglyphics on a papyrus scroll found under the mummified head of an Egyptian pharaoh? Was the secret pried despite great peril from a remote tribe of Native Americans? Figure 8 shows the cover of a dime-novel-length pamphlet advertising Judson's Mountain Herb Pills.[15] The formula was purportedly acquired by a Dr. Cunard from an Aztec sachem as reward for rescuing his daughter Tula from the clutches of the savage Navajos.

Much of what we know about many major patent medicine proprietors, indeed, comes from highly fictionalized accounts, prepared for promotional purposes, of how they got started in the

---

11. Thomas D. Clark, *Pills, Petticoats, and Plows: The Southern Country Store* (Indianapolis, Ind.: Bobbs-Merrill, 1944) and *The Southern Country Editor* (Indianapolis, Ind.: Bobbs-Merrill, 1948).

12. James Harvey Young, *The Toadstool Millionaires: A Social History of Patent Medicines before Federal Regulation* (Princeton, N.J.: Princeton University Press, 1961) and *The Medical Messiahs: A Social History of Health Quackery in Twentieth-Century America* (Princeton, N.J.: Princeton University Press, 1967).

13. Grete de Francesco, *The Power of the Charlatan* (New Haven, Conn.: Yale University Press, 1939), pp. 128 and 131–132.

14. Young, *Toadstool Millionaires*, pp. 173–180.

15. Anonymous, *The Rescue of Tula* (New York: B. L. Judson, 1859).

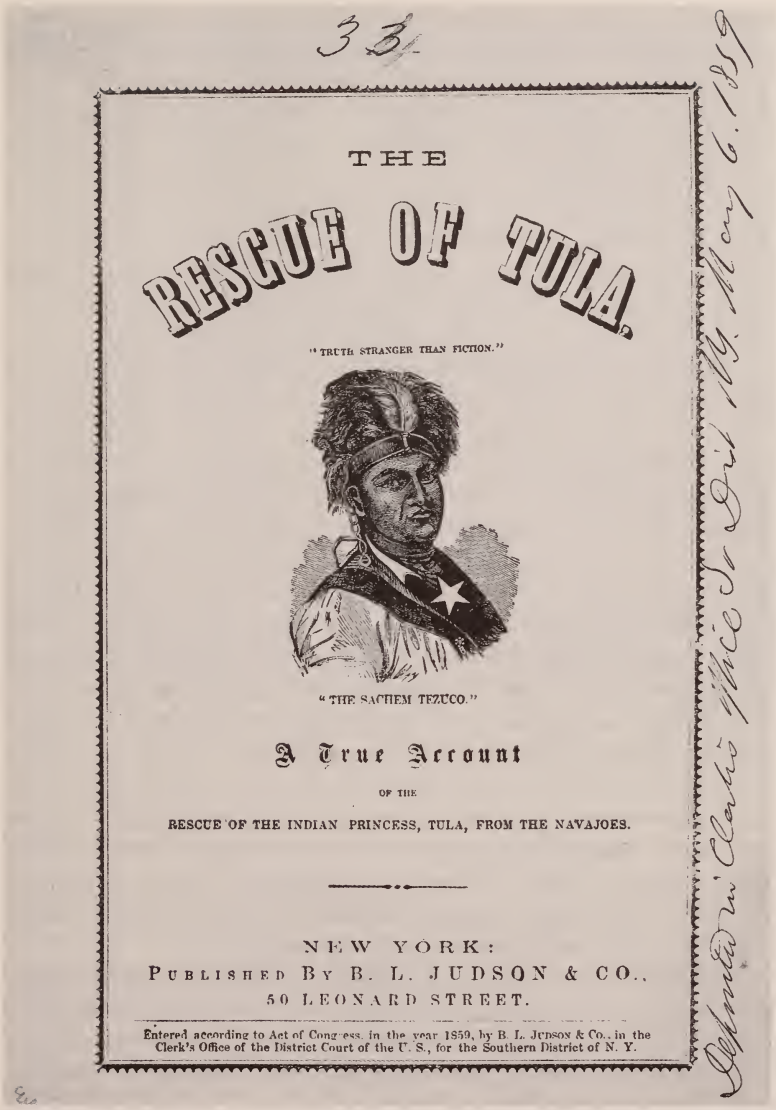

Figure 8. Title page of a promotional pamphlet imitating the dime novel genre for one of the numerous nostrums trafficking on their asserted Native American origins.

From the Collection of the Library of Congress.

business. So far as I am aware, the only well-known proprietary concern that has turned its documentary files over to an archives for researchers to consult is the Lydia E. Pinkham Medicine Company. Upon its dissolution, while selling the right to make the Vegetable Compound to another company, the Pinkham concern gave its records to the Arthur and Elizabeth Schlesinger Library on the History of Women in America at Radcliffe College.[16] Withheld from the gift and destroyed were thousands of letters written to Lydia and her successors from women seeking health counsel, letters Lydia had promised in her advertising would never be seen by the eyes of men.

In *The Toadstool Millionaires* I used case histories to help make lucid and vivid certain facets of the nostrum racket. I told stories of Thomas Dyott (see Fig. 9) and William Swaim (see Fig. 10) of Philadelphia in presenting the first period — the 1820s — in which the evils of patent medicines received extensive criticism. I recounted the career of Benjamin Brandreth and his Vegetable Universal Pills in explaining the tangled interactions between the proprietary business and the press. I narrated the adventures of David Hostetter and his Bitters in elucidating that class of reading matter, next to the Bible, most universally found in American homes, the patent medicine almanac (see Fig. 11). And I used William Radam and his bottled Microbe Killer to show how even such a stellar scientific concept as the germ theory could be torn from context and twisted to the profit of the quack.

Likewise, in *The Medical Messiahs* I told stories to help make my points compellingly. Marmola meant weight-reduction fraud; Ruth Drown's Radio Therapeutic Instrument, device deception; Adolphus Hohensee, nutrition nonsense; Harry Hoxsey, cancer quackery; the Kaadt brothers, diabetes deviltry.

The striving for food and drug laws and the coming of regulation brought an advantage to the historical story-teller that he had not enjoyed in describing earlier times. Up to this point, the novelist had held a monopoly of direct discourse, the product of his imagination. Now Congressional committee hearings reproduced verbatim the give and take of query and answer. The *Congressional Record,* although "corrected" slightly in proof to modify what was really

16. Conversation with Diane M. Dorsey, archivist, The Arthur and Elizabeth Schlesinger Library on the History of Women in America, Radcliffe College, Cambridge, Massachusetts, 8 October 1971; Eva Mosely, curator of manuscripts, Schlesinger Library, to author, 18 February 1975.

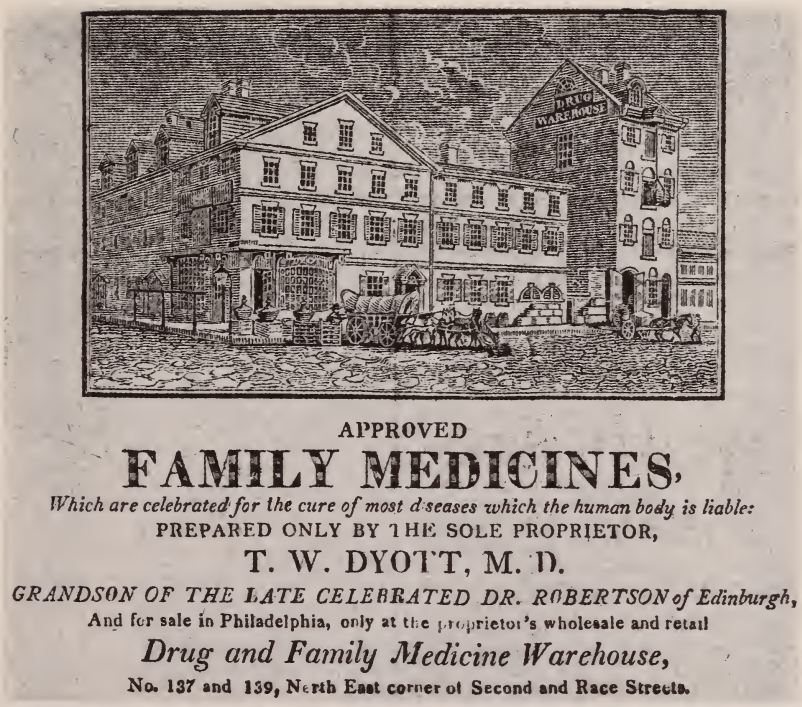

Figure 9. From his Philadelphia warehouse, Thomas W. Dyott sent by Conestoga wagon a wide assortment of his proprietary medicines to all sections of the nation.

From the *Aurora General Advertiser*, Philadelphia, 3 January 1821, in the Collections of the Library of Congress.

said, provided often powerful oratory and sharp exchange. The transcript of record of trials in federal district courts contained the words truly spoken by lawyers, witnesses, and judges. These transcripts are sometimes available for cases ruled on by the Supreme Court in that august body's library, and some transcripts of cases not appealed form part of the case jackets in the Food and Drug Administration (FDA) archives. Excerpts from such direct discourse cited in historical writing can give a sense of immediacy, provide an interlude of drama, catch atmosphere, and enhance meaning.

At a trial in Indiana during 1948, Leonard, a diabetic boy of 13, is testifying as to advice given him two years before at a clinic in South Whitley run by two elderly physicians, the Kaadt brothers

Figure 10. In a neoclassic period, William Swaim of Philadelphia chose Hercules as the symbol of the conquering powers of his Panacea over the Hydra-like multiplicity of disease.

From the *Democratic Press*, Philadelphia, 28 April 1827, in the Collections of the Library of Congress.

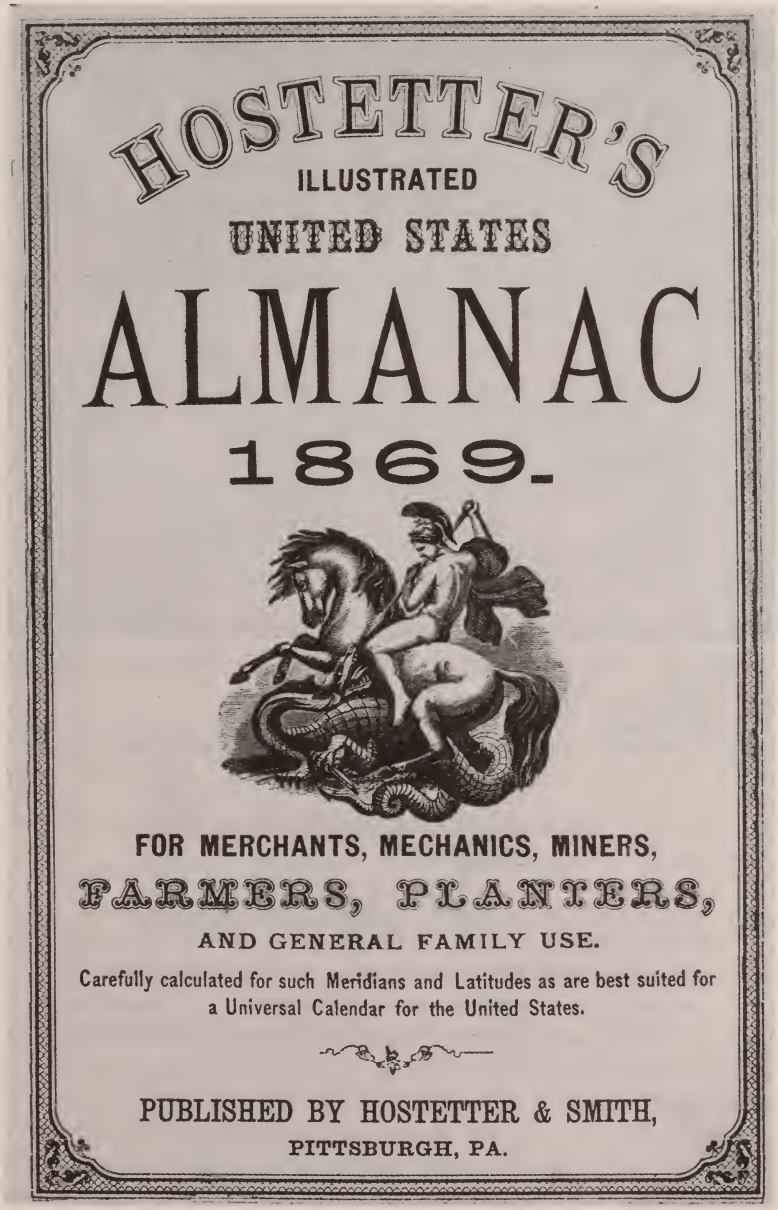

Figure 11. Hostetter's Bitters was an 80-proof patent medicine whose Pittsburgh proprietors for decades furnished almanacs in many languages to the diverse American populace.
From the author's collection.

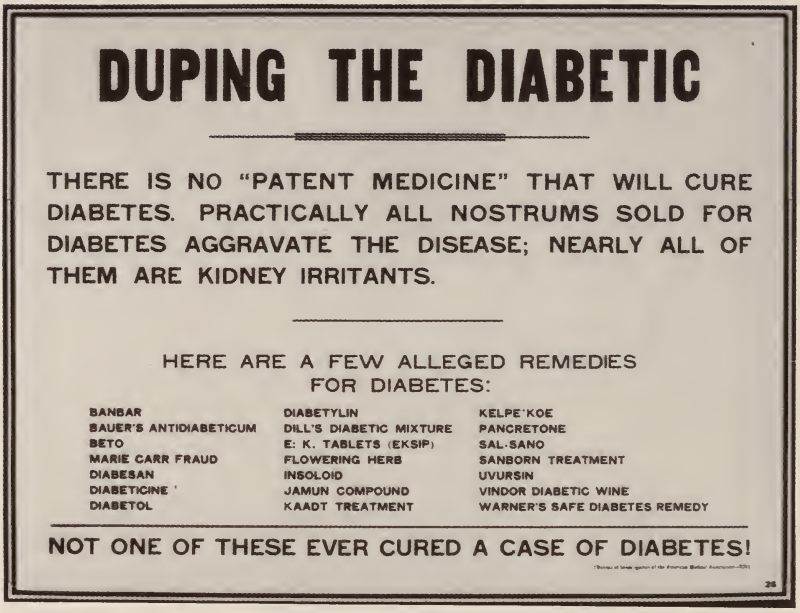

Figure 12. Diabetes quackery ran rampant both before and after the discovery of insulin treatment.

Poster listed in an American Medical Association catalog, *Material Prepared and Issued by the Bureau of Investigation of the American Medical Association* (Chicago, Ill.: AMA, circa 1940).

(see Fig. 12).[17] Leonard had taken rough notes at the time, and now he is asked to read them to the court.

> "Honey is best," he reads. "You can . . . eat all you want . . . . Boiled sugar is safe . . . . You can drink whiskey . . . . It is good for diabetes . . . . Smoking does not affect diabetes in any way . . . . Insulin is cause of bloating . . . . Not due to pancreas . . . . Not due to shock . . . . You should always have sugar in urine."
>
> "Read that again," the district attorney requests.

17. Young, *Medical Messiahs*, pp. 217–238; *Transcript of Record in the United States Circuit Court of Appeals for the Seventh Circuit, No. 9617, The United States of America, Plaintiff-Appellee, vs. Dr. Charles F. Kaadt, Defendant-Appellant; No. 9618, The United States of America, Plaintiff-Appellee, vs. Dr. Peter S. Kaadt, Defendant-Appellant; Appeals from the District Court of the United States for the Northern District of Indiana, Fort Wayne Division* (Indianapolis, Ind., 1948).

> "You should always have sugar in urine . . . ," the boy complies. "Do not ever get [a] blood sugar [test], it is dangerous . . . . The less insulin, the better . . . . "

The boy's mother follows him to the witness chair. Getting home from the clinic, she says, the boy had curtailed his insulin and abandoned his diet. Soon, at a birthday party, he had eaten ice cream and cake.

> "In the morning," the mother testifies, "I went to call Leonard for school and he appeared lazy and did not care to get up."
>
> "What did you do then?" the government attorney prompts.
>
> "I thought I would get him a glass of milk, and he began to throw up, and went back to lie down . . . . In the afternoon he seemed more lazy and in a stupor, sort of . . . . He was flushed . . . . He began to breathe heavy, and just then, when my husband came, he said, 'Call his doctor.' "
>
> "I said no, no, because he is taking this treatment [a vinegar-saltpeter mix] he is supposed to have some kind of reaction."

But at one o'clock that night, the parents took their son to the hospital.

> "Is Leonard taking the Kaadt treatment today?" the district attorney asks.
>
> "No."
>
> "Is he taking insulin today?"
>
> "Yes, sir."
>
> "How is he getting along today?"
>
> "Wonderful. He is growing fast. He is brilliant in school."

Each of the doctor brothers was fined $7,000 and sent to prison for four years.

The discouraging aspect of quackery, of course, is that similar sad stories can still be told, that health deception demands continuing pursuit. In the year I finished writing *The Medical Messiahs,* 1966, an informed official, guessing at the annual bill for our nation's quackery, put the sum at two billion dollars.[18] Last year, as I was drafting an update chapter for a new paperback edition of the book to be published in spring 1992, the best guess of another

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18. Young, *Medical Messiahs,* p. vii.

expert for the current toll was 28 billion,[19] and I have seen 30 billion since.

In the cancer field, the most complex tale concerns the rise and fall — but not the demise — of Laetrile.[20] The cyanide-containing compound was first marketed as a chemotherapeutic agent, then as a new vitamin, finally as the crown jewel in a regal diadem of multiple therapies. It gained a dozen years of legal importation and interstate distribution through the decision of one federal district judge, finally ended as the result of Supreme Court action. Laetrile, furthermore, won some kind of special status in half the states as a result of high-pressure lobbying by ardent support organizations waving the "freedom of medical choice" banner. This pressure grew so great that the Congressionally enacted and Supreme Court approved legal system of new drug approval, by which a drug's sponsor is responsible for undertaking the tests demonstrating safety and effectiveness, became short-circuited. Instead, the National Institutes of Health felt it necessary to conduct clinical trials. These demonstrated that Laetrile was not effective for treating cancer and that its cyanide content posed hazards. Laetrile, like several preceding unorthodoxies that had had their time in vogue, may still be secured in Mexico, and, I understand, may be ordered in the United States by phone. When AIDS surfaced a decade ago as a devastating disease, Laetrile, like other discredited cancer treatments, was ballyhooed as a cure.

With respect to AIDS, no single specious treatment has assumed the dominant place that Laetrile once held among cancer unorthodoxies. Instead, the number of quack options has been legion (see Fig. 13).[21] Substances proffered for injection into the body alone have included amino acids, blood serum, cells from fetal animals, Easter lily bulbs, hydrogen peroxide, ozone, polio vaccine, pond scum, snake venom, vitamins, and the sufferer's own filtered urine. Moreover, with medicines of proven effectiveness in treating AIDS and its attendant afflictions so very few, a wide range of unproven

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19. James A. Lowell and Alison E. Lowell, *Quackery and the Elderly* (New York: American Council on Science and Health, 1990), p. 1.

20. James Harvey Young, "Laetrile in Historical Perspective," in Gerald E. Markle and James C. Petersen, eds., *Politics, Science, and Cancer: The Laetrile Phenomenon* (Boulder, Colo.: Westview Press, 1980), pp. 11–60. An updated version of this chapter will be included in James Harvey Young, *American Health Quackery: Collected Essays* (Princeton, N.J.: Princeton University Press, 1992).

21. This paragraph on unproven treatments for AIDS uses material from a chapter on this theme in *American Health Quackery.*

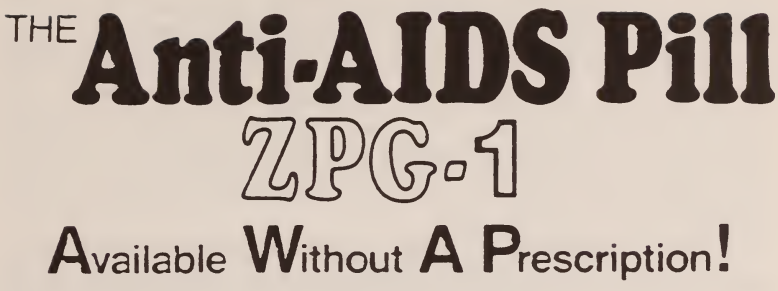

Figure 13. Fear of AIDS spawned scores of nostrums and devices promising prevention and cure.
Courtesy of the Food and Drug Administration.

medications has been resorted to quickly, a few later proving of value, some a disaster, many not yet fully evaluated. One example of this type is dextran sulfate, a drug that had been sold over-the-counter in Japan for two decades to thin blood and control cholesterol.

In 1986 this drug was shown to stop the spread of the HIV virus between cells during in-vitro tests, so a small clinical trial was launched and larger ones scheduled. The untested drug began to pour into the AIDS underground. It "was carried by flight attendants," a reporter wrote, "mailed by American expatriates living in Tokyo and smuggled across the border from Mexico."[22] Shady entrepreneurs made huge single purchases in Japan and mailed dextran sulfate across the Pacific in packages marked "tea sets" and "Japanese dolls." As this widespread underground use of the drug continued, the FDA eased its official policy on the importation of unapproved medications by patients wishing to use the drugs solely for their own treatment under the guidance of physicians. The policy also permitted the importation by mail of such personal use quotas. This was one of a number of steps the FDA had begun to take, under the combined influence of the Reagan-Bush anti-regulatory attitude and of AIDS organization pressure, to speed up the new drug testing process and to authorize earlier use of drugs still under study by patients with life-threatening diseases. These

22. Joshua Hammer, "Inside the Illegal AIDS Drug Trade," *Newsweek,* 15 August 1988, pp. 41–42.

relaxations of the rules precipitated a sharp debate among medical scientists, but the trend toward speedier access to new drugs continues. Preliminary data from the dextran sulfate clinical trials seemed to show that it was not sufficiently absorbed into the bloodstream to make it likely that the drug could protect the infection-fighting white blood cells against the HIV virus. It looked as if another hope might fail. Underground use of the drug, however, I was told recently at the FDA, continues.

Stories continue to contest against stories. The tales told by quacks seek to make their shady therapies sound plausible to the public. A host of unorthodox practitioners, as two philosophers assert, are striving to develop a counterparadigm espousing pseudoscience, making its health concepts appear more true, effective, and appealing than the tenets of scientific medicine.[23] And, as a sociologist has observed, "the fate of medical social movements is not determined by the soundness of their theories or the effectiveness of their therapies, but by their ability to mobilize political and social resources effectively."[24] The near-success of the Laetrile campaign reveals that those who believe in scientific medicine constantly confront a risk of losing. With so much at hazard, those dedicated to the cause of science and reason must continue to tell their stories.

272 Heaton Park Drive
Decatur, GA 30030

23. Clark Glymour and Douglas Stalker, "Engineers, Cranks, Physicians, Magicians," *New England Journal of Medicine,* 1983, *308*:960–964.

24. Marcine J. Cohen, "Medical Social Movements in the United States (1820–1982): The Case of Osteopathy" (Ph.D. dissertation, University of California, San Diego, 1983), p. xii.

James W. Kennedy, M.D., and the Joseph Price Memorial Hospital: Recollections

FREDERICK MURTAGH

It was my good fortune in 1942 to spend my senior year in medical school as an intern at the Joseph Price Hospital, a 50-bed private hospital in Philadelphia founded by Dr. Joseph Price in 1891.

Price was an 1877 graduate of the University of Pennsylvania Medical School. He gained eminence through his work at the Philadelphia dispensary and the Preston Retreat, where he established services in obstetrics and gynecology, and developed the techniques for abdominal and gynecological surgery. Known as a great clinical teacher, he was considered by many to be the father of abdominal surgery in America, although he never held an academic appointment in a medical school. A tireless worker, he believed strongly in aseptic techniques at a time when many of his fellow physicians did not. He was also an outspoken, controversial figure who sometimes severely criticized his colleagues.

In 1891, Price established his own private hospital at 241 North Eighteenth Street, in Philadelphia. All patients were treated regardless of race, creed, color, or financial means. He disdained financial support from other institutions or from local or state governments, knowing that if it was once accepted, he would no longer be in complete charge. In his hospital he was visited regularly by outstanding surgeons from around the world who wanted to learn the techniques of abdominal and perineal surgery. For many years, annual visits were made by the Mayo brothers.

Dr. James W. Kennedy, a native of Kansas and an 1899 graduate of the Jefferson Medical College, joined Price in his practice around the turn of the century. Kennedy worked with him for 11 years and, at the time of Price's death in 1911 became his professional heir. Kennedy acquired the hospital and became neurosurgeon-in-chief, a position he still held in 1942, the year that I was there. He was by then 70 years of age, had been practicing for over 40 years, and was not only the student of Joseph Price, but his absolute disciple. Kennedy always spoke of his predecessor in the present tense as though Price were about to pop in at any moment.

Transactions & Studies of the College of Physicians of Philadelphia, Ser. 5, Vol. 14, No. 1 (1992); 73-82
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Each year Kennedy took two senior medical students into the Joseph Price Hospital as interns, providing them with room and board. They in turn functioned as house officers, working up the patients as they were admitted, and looking after them on nights and weekends. Theoretically, the medical students were supposed to attend classes during the day, but they frequently stayed at the hospital to help with the surgery instead. It was a pure, pre-Flexner sort of arrangement. No financial consideration was offered, nor was it expected. When I had the position, I was only too happy for the opportunity to be in close contact with patients and also to be on a one-to-one basis with an experienced surgeon. Later, I was greatly disturbed to find that my successors demanded to be paid money for this experience. To me, this was the first crack in the dignity of the profession and has led to its deterioration.

It was under these circumstances that Jackson Dunning, from the University of Pennsylvania, and I, from Temple University, entered the Joseph Price Hospital at the beginning of our senior year in May 1942 (see Fig. 1).

The hospital was housed in two large, adjoining four-storey brownstone mansions. A massive bay window fronted each of the houses, bracketing a common entrance at the top of six granite steps guarded by two high oak doors with beveled glass panels. Walking through these doors was like stepping back 25 years into the past.

The two houses had been broken through at every level to make one building with all patient care activities housed on the north side and facilities for support services and a nursing school on the south side. Examining rooms throughout the hospital were furnished in much the same manner: plain metal furniture painted white, with an examining table, a glass-door cabinet for instruments, a small table with a sterilizer, and a writing desk and chair. The floors were tile and the entire room painted white.

On the first floor, a long hall toward the back of the hospital led past utility rooms, single occupancy patient rooms, a nursing station and, at the very back, a four-bed "ward." All floors were bare, walls and wood work were painted white, and the rooms were furnished with iron beds, a small bedside stand with a lamp, and a single chair. One overhead light with a glass shade hung from the ceiling in each room. There were shades on each of the windows, but no drapes — all in the name of cleanliness and sterility. Bathrooms were really considered unnecessary because most patients

Figure 1. Frederick Murtagh, James W. Kennedy, and Jackson Dunning, 1942, Joseph Price Hospital, Philadelphia, Pennsylvania.
Courtesy of Dr. Frederick Murtagh.

were kept strictly in bed, their needs attended to by the nurses. The second and third floors contained mostly patients' rooms, all of them single occupancy and starkly furnished to provide only the most basic needs for patient care.

The fourth floor contained quarters for the interns in the front on the Eighteenth Street side. Just past a stairwell was a labor room containing a single bed, a chair, a cabinet for supplies and a scrub sink. A wide doorway led into the adjacent delivery room, which was slightly larger than the labor room and contained two scrub sinks against the front wall. Perpendicular to the back wall stood the delivery table, with a breakaway section which could be removed at

the time of delivery. There was a cabinet for supplies and medications and one or two rolling metal stands to hold instruments. The next room back was an anteroom to the main operating room. This room contained two large autoclaves, metal cabinets for the storage of instruments, supply cabinets, and work tables for putting up instrument packages and linens. On the north side of the room were two scrub sinks. In spite of its general use for sterilization purposes, this was known as the "dirty room," because the surgeons' scrub ritual began here in the two "dirty" sinks, before moving to the main operating room, where the ritual continued through four "clean" sinks.

The main operating room extended across the back of the building and measured approximately 20 by 30 feet. Entrance was through a doorway from the preparation room or directly from the hallway. This room had a blazing bright white appearance with a smooth tile floor and the three walls and ceiling all painted white. The back wall facing east was all paned glass which admitted the light of the morning sun as it rose over the Seventeenth Street rooftops. The operating table was painted metal. Its head could be elevated and its foot could be dropped down to place the patient in the lithotomy position. Wheeled tables held the instruments, wheeled stands held basins of fluid such as alcohol and carbolic acid solution, a straight chair was available for the surgeon to sit on, and a stool for the anesthetist, but there were no other furnishings.

Mounted on the north wall of the operating room was a large board which looked like an oversized ironing board. On it were painted the words "Honor to Whom Honor is Due." This piece of equipment was said to be Price's original operating table. During his career, Price had not only operated at the Preston Retreat and the Philadelphia dispensary, as well as at many other hospitals, but he had also traveled to rural areas and performed surgery on patients in their own kitchens. He carried this "ironing board" with him wherever he went and used it as his operating table, placing it on top of kitchen tables.

Until the 1930s, the Joseph Price Hospital had supported a diploma school of nursing. The school had turned out some of the Philadelphia area's best nurses, all of whom were very much in demand by most of the local and regional hospitals. In 1942, when I worked there, the corps of nurses functioning in the hospital were graduates of this earlier program and most of them lived in the

hospital. The right side of the building, or the south house, was originally designed to support the nursing school and to provide accommodation for live-in nurses and employees of the hospital. On the first floor in the front there was a formal parlor elaborately furnished with oriental rugs, damask draperies, and early twentieth-century furniture. This room was used for receptions, for graduations of the nursing classes, for live-in persons to entertain friends, and for general social functions. It was also a waiting room where patients' families could gather and be counseled.

A dining room behind the parlor accommodated about 35 persons. Behind this was the kitchen. Off to the left in this area was the X-ray room and behind that the laboratory, where blood counts, chemistries, and the preparation of pathological specimens were done. The second, third, and fourth floors of this part of the hospital were not openly connected with the other building, but were cut through with closed doors which could be locked. This area contained mostly domestic quarters for the live-in nurses or other support personnel such as the dietitian, laboratory technicians, and so on. It also contained classrooms and dormitories for the former school of nursing.

Dr. Kennedy was absolute patriarch of this small domain. He was a tall, thin, Lincolnesque person with crisp, clean-shaven, angular features, and large powerful hands. At the age of 70, he was in perfect physical condition. The man looked as though he had spent all of his life on the Kansas plains rather than in a surgical operating room. He was precise in all of his activities — never a wasted movement. He lived at the Embassy Apartments at Eighteenth and Spruce Streets with his wife Jean, and walked to the hospital each morning. With long, measured strides he would enter the building through a rear doorway. At the very moment he strode into the reception room, the grandfather clock would bong the hour of eight, announcing to the entire institution that Kennedy was in the house. The whole place snapped to attention.

Kennedy was greatly revered and at the same time feared. He was affectionately known as "Pap" to the nursing staff and the byword around the hospital was "Jesus Christ, Joseph Price, and Dr. Kennedy," but he was always addressed directly as "Dr. Kennedy." He was a quiet, gentle person in contrast to Joseph Price, and not as outspoken as his mentor. At the same time, he was not above criticizing his colleagues in private conversation, but never publicly or in writing. When mistakes were made in hospital mat-

ters, however, he had no difficulty expressing his displeasure. For recreation, he liked to putter around his small farm in Mantua, New Jersey. His favorite diversion was a trip to Kansas to shoot jackrabbits, and he would always bring back several pairs of rabbit's ears as testimony of his skill with a 22-caliber rifle.

Professionally, Kennedy was the true disciple of Price and followed Price's teaching, philosophy, and techniques to the letter. Kennedy made minor concessions to "modern medicine," such as wearing surgical gloves to operate, but only if there were visiting firemen in the operating room. He preferred to operate bare-handed after a meticulous 45-minute scrub in a series of scalded sinks and a basin of sterile water. He claimed the use of gloves dulled his surgical "touch," was traumatizing to tissues, and, in general, robbed the surgeon of his aseptic consciousness.

All diagnoses were made on clinical evidence alone; Kennedy quietly listened to the patient's complaints and symptoms, all the while appraising the patient visually — assessing apparent age, state of nutrition, skin color and turgor, the facies, and level of physical distress. He then usually put a hand on the patient's brow, looked at the conjunctiva, put a finger on the pulse, and finally, a hand on the abdomen and, if necessary, made an internal examination. Kennedy might get a blood count or a chest X-ray for the record but only to demonstrate his recognition of contemporary means of clinching a diagnosis.

Kennedy's surgery was swift and precise, without a wasted motion. In abdominal operations, he rarely used mechanical retractors, preferring that his assistant use his hands for that purpose. Intestinal anastomoses were accomplished with a Murphy button and he did gastric resections with straight clamps and over-sewing, all in a very crisp manner. No matter what the problem, we were never at the operating table for more than 45 minutes. Closures were made with hand-held straight needles through all layers of the abdomen with silkworm gut secured with lead shot.

At the time I was at the Joseph Price Hospital, Dr. Peter Marvel provided the medical back-up. He was the classic example of the kind and gentle family physician who delivered babies, made housecalls, had an intense interest in his patients, and was a fountainhead of practical knowledge and information. Dr. Mary Hipple, a solid woman bucking a man's world, also provided excellent medical back-up and Dr. Robert Shoemaker, a radiologist, would stop in almost daily to interpret the few films that were taken.

In 1942, two physicians, Dr. William T. Lemmon, and his associate Dr. Emma Bevan, in their operations represented the state-of-the-art approaches to surgical problems in Philadelphia. They practiced together mostly at Thomas Jefferson Medical College, but frequently sent patients to the Joseph Price Hospital. "Wild Bill" Lemmon, as he was known, was an ecumenical surgeon who could and did cover the surgical field. I recall helping him with a vaginal repair on a patient and afterwards, while we were dressing, he asked what Dr. Temple Fay, at Temple University, was doing about brain tumors because he had to go over to Jefferson and operate on a meningioma. Lemmon had developed the technique of continuous spinal anesthesia and, of course, used it in most of his cases. Dr. Bevan was especially helpful to me and let me do many of her obstetrical cases. Kennedy welcomed these doctors to the Price Hospital, but was often privately critical of their methods, which he considered to be departures from the basic concepts of surgical practice.

The nurses at the Joseph Price Hospital were professionals, trained from the first day in the hospital's own diploma school of nursing to take care of patients. A few of the younger nurses in 1942 had come from other training programs, but they were quickly indoctrinated in the principles of primary patient care at the Price Hospital. I never saw a nurse on duty who was not starched and primed to the nines. Their hair was always carefully pinned up and they wore no make-up, jewelry, or fingernail polish that might spread contamination. They stood at attention when a doctor entered the room, could answer any questions regarding the patient's condition, and would carry out verbal or written orders promptly and efficiently. The nurses could perform enemas, catheterize patients, give injections, dress wounds, allay a patient's fears and anxieties and, if necessary, give a turpentine stupe (the poultice-like application of a towel soaked in a heated, diluted turpentine solution, applied to the abdomen) to a patient with abdominal distension. A patient never had a wrinkled or soiled bed, nor did a patient have to wait more than a few minutes for a response to a call for help at any time of the day or night. On a cold night, the nurses saw that the sheets were warmed by a bed warmer, and if it was particularly cold, a brick heated in the kitchen stove and wrapped in heavy towels was placed by them at the foot of the patients' beds.

The most frequently performed surgical procedure at the Joseph Price Hospital was vaginal hysterectomy utilizing the Pryor

clamps, a technique developed by Price. He claimed to have performed more than four thousand such procedures during his career and, of course, Kennedy continued the work. Both surgeons were sometimes criticized by their colleagues for what were considered to be marginal indications for the procedure. The Price-Kennedy concept was that the uterus, after the child-bearing period, was a vestigial organ and the nidus of cancer. The two surgeons believed it was better removed if there was the slightest indication of problems provided it could be done quickly, easily, and with little risk to the patient. Price and Kennedy could do just that. Their average operating time for an uncomplicated vaginal hysterectomy was about six minutes. A complicated case in which the patient had fibroids or other pathology might take as long as 15 or 20 minutes. Morbidity and mortality from these operations was extremely low. From my own observation in 1942, out of a number of cases I helped with during that year, I know of no deaths and can remember only one infection.

Preparation for such a procedure usually began before daylight. Lydia Miller, chief operating room nurse, timed her "setting up" so the surgery could begin shortly after sunrise, when light poured through the operating room windows to illuminate the operative field. Dr. Harold Roxby from Swarthmore usually came in to assist at these procedures.

There was a real pecking order to the scrub ritual. Kennedy went first, followed by Roxby, and then myself as the three major participants. The nurses had scrubbed long before. Washing and hand scrubbing for the surgeons began in the "dirty room," with a timed five-minute scrub at each sink with a hard bristle brush and Ivory soap. The surgeons then advanced to the operating room and scrubbed through four scrub sinks. These sinks and the fixtures would be washed down with scalding hot water to ensure their sterility — a different sterile brush and piece of soap were used at each sink. Five minutes more scrubbing in each of these four sinks was followed by a five-minute scrub in alcohol and then a final rinsing of the hands in sterile water. This would be followed by the donning of white sterile gowns and gloves.

In the meantime, the patient had been set up and anesthetized. Anesthesia was by open drop ether administered by whomever happened to be standing around and apparently not doing anything. This could be a visiting professor, a stray medical student, the patient's referring physician, or a nurse. The anesthesia, of course,

was completely under the direction of James Kennedy. His instructions to the anesthetist were to place an oversized, gauze-covered kitchen tea strainer over the patient's nose and mouth and liberally to pour ether directly from the can onto the mask. The anesthetist kept a finger under the angle of the patient's jaw to keep her from "swallowing her tongue," and when she was breathing easily and regularly the ether administration would be cut down to a maintenance level for the remainder of the operation.

There was rarely any kind of intravenous line running to the patient. There might be a blood pressure cuff on the patient during the operation, but the pressure was rarely taken. The level of anesthesia was determined simply by monitoring the patient's pulse, respiratory rate, and pupils of the eyes. Every once in a while during the operation, Kennedy would look up and inquire about the patient's condition and, when he was finished, he would simply stand up and say, "O.K., throw it away," meaning to throw away the ether. Usually the patient awakened in a few minutes with or without the help of some oxygen. For all operative procedures, even a simple appendectomy, the patient was kept in bed for a minimum of five days and often for as long as two weeks. I have no recollection of any patient developing pulmonary complications or thrombophlebitis.

Simple mastectomy was Kennedy's procedure of choice for carcinoma of the breast, usually with the removal of as much of the "cancer" as he could see grossly. Since the choice of simple mastectomy over radical mastectomy is still a controversial issue, I would like to know where Kennedy's records are, because he did a number of these operations. I am not aware that there has ever been a follow-up of these cases.

All doctors who referred patients to the Joseph Price Hospital did obstetrics and I participated in a significant number of deliveries assisting others and also did a number of them myself, particularly on weekends, when the attending physician was unavailable. Deliveries were made with the help of a little nitrous oxide for the mother and again any repairs necessary were made with straight needle and silkworm gut secured with lead shot. Dr. Thaddeus Montgomery was professor of obstetrics at Temple University at that time, and my experience at the Joseph Price Hospital was sufficient for him to agree that my work there qualified as my senior obstetrics rotation.

My graduation from medical school on 16 March 1943 ended this phase of my relationship with the Joseph Price Hospital. Fortu-

nately, I was able to continue it for a period in 1946–1947. My early impressions of pure professionalism in medicine, the dignity of the profession, a direct, no nonsense approach to problems, and a sense of aseptic consciousness were the most valuable of my early years, and have supported me for the past 40 years of practice.

Postscript

On 15 May 1950, with the retirement of Kennedy, the Joseph Price Hospital closed its doors. It was eventually demolished to make way for the Vine Street Expressway.

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An Indescribable Feeling of Wretchedness: Letters to Samuel Jackson on Epilepsy

JACK ECKERT

Among the rich collections documenting the development of American medicine held by the College of Physicians of Philadelphia is a recently catalogued cache of letters preserved by physician and educator Samuel Jackson. The letters are unusual because they concern nineteenth-century descriptions and treatments of a particular and then little-understood ailment — epilepsy — from the standpoint of both physician and patient.

Jackson (1787–1872) received his M.D. from the University of Pennsylvania in 1808 and studied under James Hutchinson and Caspar Wistar. After a brief period in the family pharmaceutical business, he became a founder and trustee of the Philadelphia College of Pharmacy in 1821. He taught materia medica and pharmacy there until 1827, then began to teach physiology, assisting Nathaniel Chapman at the University of Pennsylvania. From 1835 until his retirement in 1863, Jackson held the professorship of the institutes of medicine at the University. He was an active Fellow of the College of Physicians and a member of the Philadelphia Medical Society and the Medical Society of the State of Pennsylvania.

The collection contains over 20 letters, many of substantial length, dating from 1839 to 1860. These letters, written by a number of physicians who were, almost exclusively, graduates of the University of Pennsylvania practicing in the southern United States, contain meticulous observations of the case histories, symptoms, and treatments employed in their epilepsy patients. The cases document the treatments and drugs generally prescribed as well as the uncertainty and fear attending the physicians as they confront an illness which they feel ill-equipped to handle. Possible theories for the cause of epilepsy and onset of its seizures are also evidenced in the letters; diet and climate are common explanations, and, interestingly, at least two of the physicians tied the epileptic seizures to phases of the moon.

The letters addressed to Jackson ask for his advice on possible ways to treat the disease or eliminate the suffering of patients. It is notable that Jackson's former students continued to turn to him as

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an authority on the subject and, although often working on cases in consultation with local practitioners, call on the university professor for assistance. Jackson's responses have, unfortunately, not survived, though several letters refer to his prescribed regimen of diet, certain medications, such as nitrate of silver, and cold water bathing.

Even more interesting are the letters written to Samuel Jackson by epileptics, as they use their own words to describe experiences with the affliction. It is rare, in primary source materials for the history of medicine, to gain an understanding of a disease from the inside, as it were. The patients use vivid, subjective phrases in their attempts to describe the sensations preceding a seizure, such as "the aura," "the glimmering before my eyes," "water rushing over a dam," and "an indescribable feeling of wretchedness."

Fifteen of the twenty-two letters to Jackson in the collection, including letters from epileptics W. C. Haymond and A. F. Gregory and family members of epileptics, and case descriptions by physicians Richard D. Arnold, William B. Cochran, Francis H. Deane, Virginius W. Harrison, William B. Pleasants, John Thomas Pritner, John Seibert, George William McKenzie Semple, and Edmund P. Taliaferro, are transcribed here. The letters may raise more questions than they answer. Why, for instance, are most of the letters from Southern practitioners? Why did Jackson keep them? And what advice did he give to both doctors and patients? Despite the questions, the letters shed light on the practice of medicine in the antebellum American South and the intellectual processes of observation employed by physicians coping with a medical mystery.[1]

Letter 1. William B. Pleasants[2] to Samuel Jackson, Providence, Va., 8 October 1839.

Dear Sir:

May I hope that you will pardon the liberty I have taken in earnestly soliciting your advice in a case which has caused the deepest anxiety on my part and baffled the skill of some most eminent practitioners. The case I

1. For a discussion of the stigmatization of early twentieth-century epileptic patients and the work of the Craig Colony for Epileptics in New York, see Ellen Dwyer, "Stigma and Epilepsy," *Transactions & Studies of the College of Physicians of Philadelphia*, 1991, *13*:387–410.

2. William B. Pleasants, M.D. University of Pennsylvania, 1839, Virginia, practitioner.

allude to is one of epilepsy, in the person of my brother, aged 24 years. The history of the case is as follows, as far as I can collect the particulars.

Early in the month of March last, he became very much heated and fatigued, in some project with his gun over a wood fire, and was discovered to have swooned or fainted; he, however, soon recovered and was apparently well for months afterward, but has since confessed that he had several successive intimations of an approaching syncope, or, rather, as he expresses it, an indescribable feeling of wretchedness, accompanied with almost total blindness for a short time. About the first of June last, after eating heartily at tea, of clabber & honey, and having just laid down, we were aroused by the cry that he was dying. I was summoned to his assistance immediately and found him completely convulsed. The contents of his stomach were soon thrown off, by an emetic first (or, I rather think, spontaneously) and an active cathartic administered forthwith. In 7 or 8 hours, however, another convulsion followed, and after a course of depletive & revulsive treatment, they were arrested for 8 or 10 weeks. Unfortunately, however, on one occasion, he overleaped the bounds of dietetic treatment which had been strictly enjoined & followed out till then, and the consequence was that another spell of paroxysms succeeded and have since recurred at intervals of 2 weeks and, perhaps a little remarkable, precisely at the change & full of the moon.

I consulted Dr. Mettauer,[3] an eminent physician in Va., about the case. He put me upon the following treatment. Inasmuch as there was evidently existing great torpor of the liver and, consequently, pretty obstinate constipation, he advised the use of the nitro-muriatic bath over the region of that organ. Solution of aloes and potash, for the purpose of an aperient and also with a view of exciting the hemorrhoidal vessels of the rectum. The application of tartar emetic ointment to the dorsal spine, leeching & cupping the temples, as his condition required, and a strict adherence to a regulated diet — weak coffee in the morning with bran bread, soup for dinner, with a roasted Irish potato and a few stewed tomatoes, a cracker, & hot water tea for supper. His exercise has been regulated by his strength, and we have endeavored, in a word, to keep him from the influence of every thing calculated to excite or fatigue. In spite, however, of every attempt, he has had another attack of convulsions. Perhaps I should have mentioned that he is a man of middle stature, weighing about 140 lbs. while in health, and somewhat disposed to a plethoric condition of system, in other words, his system seems to possess considerable recuperative energy, recovering rapidly after most powerful depletion.

His condition now I cannot think (should he be attacked again) would possibly admit of farther depletive means with lancet. I have not ventured upon the class of nervine remedies and, in fact, feel greatly at a loss what

3. Probably John Peter Mettauer (1787–1875), M.D. University of Pennsylvania, 1809, and a noted Virginia surgeon.

to do, until I hear from you. Perhaps a most important item I have yet to notice; that is, his grandmother was a subject of epileptic paroxysms for a number of years, though finally died of another affection.

From the facts I have collected about the case, I am under the impression that they originate principally from gastric irritation and earnestly hope that they have no dependence or hereditary transmission. This your own skill must decide, as well as you can, from the hasty and unconnected history of the case. I do hope that you will kindly lend your advice to one who had the honor of listening to your instructive voice last session and who must ever cherish the highest respect for your professional skill.

May I still farther trespass upon your patience and ask your advice about my sister, who was taken with a convulsion, sometime since, after sitting up with & watching him with assiduous attention, during one of his attacks. May it not be entirely the influence of the imagination, acting on a nervous system, wrought up to the highest degree of sensibility? Please write to me, as soon as your professional engagements will permit, and give me a detailed treatment of the cases. Please specify the proper dietetic treatment also — I mean the articles of diet proper for them. They are generally comprehended under the term "light," which is rather indefinite, for instance, some physicians prohibit coffee, others recommend it; some forbid the lighter meats altogether, others advise them.

I fear I have already wearied your patience too far and must close by tendering you my warmest wishes for your health and happiness.

I remain your obedient servant,
William B. Pleasants

P.S. He has had 4 successive attacks and 11 convulsions in all. Please let me know what prospect there is for the successful treatment & permanent cure.

Letter 2. E. B. Pell to Samuel Jackson, Poughkeepsie, N.Y., 25 October 1839.

Sir:

Your letter of the 17th reached me on the 21st instant, since which I have applied the remedies recommended by you to my daughter, giving foot baths, rubbing the spine and extremities as directed, with every attention to diet, etc., suggested by you — except that her hair has not yet been cut off, which I thought you might deem unnecessary when informed that she has been unusually free from headache, and that her attacks have not been preceded by any pain or uneasiness in the head, and though she has complained of headache after her most violent attacks, they have never been severe nor of long duration. It may, however, be well to state that since Tuesday 22nd, when I commenced pouring cold water over her head, she

has complained of a dull, heavy headache and this morning has suffered much with a bad sick headache, and throbbing in the temples, a thing I never remember her being affected with before. Finding her head so uneasy in consequence, I have only poured water over it once a day and wait your further directions, whether you still consider it necessary she should lose her hair, and that I should persevere in bathing her head.

I will now answer your questions respecting her general health. Her bowels are most commonly in a healthy state; but she is sometimes a little troubled with costiveness and flatulency, which have been relieved by a mild aperient pill. Any irregularity of the bowels has an immediate and decided effect on the state of her nerves. Her monthly courses have never been either interrupted or deficient or attended with pain. Neither has she suffered any uneasiness of the spine, though I have examined it several times under direction of a physician with the view to detecting disease there. The spasmodic action of the muscles with which she is affected daily, more or less, are not accompanied by any sensation beyond a momentary absence of mind; and her convulsive attacks are preceded by no pain or uneasiness of any kind, except at the moment she goes off, when she afterwards describes having felt what she calls an awful feeling, a giddy whirl in her head, and a sense as of falling backwards.

In your list of articles to compose her diet, you do not mention any kind of fruit. Please to say whether you object to her taking baked apples, stewed pear, or other simple preparations of fruit.

I remain, Sir, yours respectfully,
E. B. Pell

Letter 3. Richard D. Arnold[4] to Samuel Jackson, Savannah, Ga., 23 July 1841.

Dear Sir:

Miss Madeline Williamson, being about to visit the North, I have thought it most prudent to furnish her with a letter to you, in case she should have any return of the affection for which she has been under my care. On the 30th of March last, she was seized with very violent epileptic convulsions. I ascertained afterwards that precisely four weeks anteriorly, she had been attacked in Charleston when on a visit. As the physician there had treated her entirely with spirits of hartshorn, I supposed her attack to have been hysterical, & although under my care before the 30th of March, it was not until I witnessed her convulsions that my eyes were opened to the real nature of the disease. I should state that the physician in Charleston had seen her in one of her attacks.

4. Richard Dennis Arnold (1808–1876), M.D. University of Pennsylvania, 1830, Savannah, Georgia, practitioner and educator.

Happening to be in the house at the time of her attack, I saw the whole spasm from beginning to end. I bled her from the arm copiously. The next morning, I called in Dr. Waring,[5] who had formerly been the family physician before his health interfered with his practice. Just at the time of his visit, a severe convulsion came on. She was again bled to about 20 ounces. After tying up the arm, another convulsion came on but not so violently as the others. Calomel 10 grains & two hours after castor oil were then ordered. Owing to the oil's operating badly, we substituted salts senna & manna which we afterwards found to produce very copious evacuations. Purging & low diet were continued until all fever had subsided.

Dr. Waring ordered a close surveillance to be kept upon her & I visited her daily. We ascertained that her menstruation was very scanty. On the 11th of April, she complained so much of her head that I bled her. She had a great deal of dull, heavy feeling in her head, for which I several times prescribed salts senna & manna. Her attacks commenced always by an aura beginning at the top of the little finger & running up the arm when it terminated in a violent convulsion.

On 23rd April, at 7 p.m., she was attacked by the aura, but no convulsion ensued. The general circulation was much disturbed, the pulse being full & frequent. I had wished to try a system of gradual & continued leeching behind the ears & over the spine, but she had obstinately refused to submit to that treatment. Being alarmed, she now consented, & I applied leeches over the course of the nerve in the little finger & over each mastoid process, while I bled her copiously from the arm & exhibited calomel 10 grains to be followed the next morning by salts senna & manna.

In the afternoon of the next day, Dr. Waring again met me in consultation. Her pulse having begun to rise & her head to ache, we again bled her, & if it at my night visit there was any excitement of the pulse, I was to bleed again, which I did. We continued to purge her & keep her on gruel until all general excitement had disappeared. On the 27 April, Dr. Waring ceased visiting her.

To keep her bowels open after her recovery, I prescribed pills of aloes, rhubarb, & soap. Her diet was nutritious but plain.

Since that time, she has had no attack of either the aura or convulsions. In the beginning of June, I put her upon the use of the hydriodated tincture of iron. This acted as a tonic & completely restored the menstrual function. She has greatly improved in her general health & is now much stouter & fatter than before her attack.

It has been an extremely interesting case & considering the violence of the convulsions, has, so far, eventuated much more favorably than I dared to anticipate at first. Not a single antispasmodic was resorted to. The treatment was purely antiphlogistic.

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5. Probably Georgia practitioner William Richard Waring (d. 1843), M.D. University of Pennsylvania, 1813.

Very respectfully your obedient servant,
Richard D. Arnold
(of the Class of 1830)

Letter 4. William B. Cochran[6] to Samuel Jackson, Middleburg, Va., 1 November 1844.

Dear Sir:

A patient, & friend of mine, Mr. McCarty, about thirty-four years of age, was taken on the 31st of August last with a convulsion resembling epilepsy. I was summoned in great haste, but when I arrived, the attack had passed off. It was the first time in his life he had ever had such an attack, but since then he has had four or five. They come on with a peculiar stinging sensation in the thumb & two forefingers of the left hand, gradually extending up the arm, to the muscles of the face & of the left side which are much drawn & convulsed. The left eye also rolls incessantly. He then becomes insensible for a minute or less, & the attack passes off. There is nothing of that foaming at the mouth or disposition to bite the tongue that the epileptic usually have. About three weeks previous to the first attack, he was suddenly taken with a numbness in the thumb & forefinger of the left hand, which has never left him.

His habits have been strictly temperate; he never touches alcohol in any shape. He has led a farmer's life in every respect & used a farmer's diet. He drank a good deal of coffee & used tobacco [freely?], to which two articles I attributed the symptoms of indigestion, of which he occasionally complained to me. He had also complained to me of palpitation of the heart, which I considered symptomatic of the disordered stomach.

He is frequently threatened with these attacks, that is, this peculiar tingling in his fingers comes on, & he thinks he had checked them by bathing his hand in spirit as hot as he can bear it & drinking at the same time some raw brandy. I have chiefly pursued the treatment directed by you in a lecture published in the *Medical Examiner.* I have given occasionally emetics, persisted regularly in the tonic pills, dieted him strictly, & have now a seton[7] in the back of his neck. I wish you to inform me what course you think ought to be pursued, & if any other, what treatment? Your early attention to this subject will greatly oblige, very respectfully, your friend,

William B. Cochran

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6. William Bailey Cochran (d. 1898), M.D. University of Pennsylvania, 1831, Middleburg, Virginia, practitioner.

7. A seton is a strip of linen, cotton, or silk, passed through the skin to promote or maintain a discharge.

Letter 5. G. W. Mc. Semple[8] to Samuel Jackson, Charles City Court House, Va., 15 April 1845.

Dear Sir:

I have a case under treatment which has perplexed me much and about which I am anxious to have your advice.

The son of Hill Carter of Shirly, in his infancy & childhood, was subject to frequent attacks of what his physician said was croup, for which he was frequently, up to the age of 9 years, in the course of every winter, treated by most copious bleedings & very large doses of calomel. In the course of 24 or 48 hours, he would often lose 20 ounces or 30 ounces of blood and take 1 drachm or 2 drachms of calomel.

I was sent for to see him during the last summer, late in August. He was then 10 years old, well-grown, light hair, black eyes, fair, florid complexion, full chest, sprightly, intelligent mind. During the past winter, he had had no attack of croup & was apparently in fine health. His pulse was regular & his secretions good. His bowels regularly open twice daily & his appetite and digestion good. His parents informed me that all they saw amiss in their boy was a frequent loss of consciousness for a few moments at a time. His countenance would assume a fixed, vacant expression. If he were in motion, he would stop and remain fixed. If reading, he would stop and, after a long, deep-drawn sigh, go on from the place he had left. He was fond of rowing a little boat on the river with his brother & would often lose several strokes of his oar. He was entirely unconscious of anything unusual.

I advised he should be restricted in his diet to bread and milk for breakfast & early supper, that he should be allowed the more digestible fresh meats at dinner with wholesome vegetables, & that the quantity of food should never be sufficient to satisfy his appetite. He was thus somewhat reduced by the middle of September. He was then ordered to have a blister kept constantly open behind each ear. The paroxysms were thus reduced about one-half in frequency.

By the 20th December, I was enabled to procure a constant supply of leeches, which would at first have been preferred to the blisters, & one was ordered every third night, behind each ear. His mother thinks that his paroxysms were for a time reduced somewhat in frequency by their use, & he has lost more flesh.

In other respects, he continues much as when I first saw him. It was my intention to have resorted to some antispasmodic & tonic medicine, but will delay any change of treatment until I hear from you, my much respected preceptor. It is not intended to impose this trouble on you without compensation, though I am sure the interest which you take in an old

8. George William McKenzie Semple (1812–1883), M.D. University of Pennsylvania, 1834. Semple was a surgeon in the Confederate Army during the Civil War.

student would procure as much from your liberality for one who has seldom troubled you. Be good enough to make out your account and forward it to me enclosed in your reply, & Mr. C. will remit you the amount through my hands when he settles my account.

Be assured of the continued respect & gratitude of your former student,
G. W. Mc. Semple

Letter 6. John Thomas Pritner[9] to Samuel Jackson, Clarion, Pa., 29 December 1846.

Dear Sir:

During my attendance at the Medical University of which you are a professor, accident placed me in your rooms a few times. From this acquaintance, I presume to ask your opinion in the following case.

A single female, age 24, called in January 1846. Complained at intervals of pain in the back part of the head, rather around the center or crown of the scalp. Also she had what she called "weak spells." She would suddenly sink down, be insensible to external impressions, the breathing and circulation continuing, though both rather slower than natural. These occurred twice and three times a week, duration from fifteen to twenty minutes. From inquiry, I found her menses regular though sparing, also leucorrhea and costiveness. I put her under treatment for the leucorrhea, etc., and in March following, she was relieved of the fluor and the menses more abundant. General health improved though still complained of pain in the head. I directed the cuticle application of morphine, cold bath, and muriated ti[ncture of?] iron with infusum quassiae. At this time she left town and returned home, 20 miles distant; heard nothing more of her until June. Summoned in haste to see her. She had the day previous suddenly fell down insensible, remained so for about an hour, when she took spasms or cramps. The muscles in the front part of the body would gradually contract until she would be drawn together as much as possible. This continued a few minutes, and she would relax, though lay insensible. In half an hour (perhaps sooner), another set of muscles, those of the back or right side or left, would contract, and so on. These attacks would last five or six hours before she would become sensible. In the interval, she would converse rationally, eat a little. Arterial circulation below the natural standard. Bowels in a natural state. Ether ammoniae, musk, and some other restoratives were resorted to with stimulating functions to the surface without any good effect, but continued for four days, increasing in severity.

I administered the quinine in twelve grain doses, an hour and a half apart. After the third dose, the peculiar effects of the medicine appeared.

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9. Probably Thomas Pritner, M.D. University of Pennsylvania, 1829, Clarion, Pennsylvania, practitioner.

It was discontinued, and that night the spasms were not so severe. For five successive mornings, the quinine was given in the doses above, and spasms ceased. Quinine was continued in smaller doses for two weeks. She gradually improved, menses regular, no fluor albus. The pain in the head continues, and she thinks that the seat of the disease. I have used in succession blistering, croton oil, tartar plasters, and she is now wearing a seton in the back of the neck. I also tried strychnia for five or six weeks, all without any sensible effect.

Three weeks ago, she fell down insensible and lay in this state for five days (no spasms), took no nourishment during this time, swallowed a little water with much difficulty. I directed a cold bath, and she was suddenly restored to consciousness. She is very weak, though now gradually improving. She is taking the quinine, using the cold bath. Senna occasionally to open the bowels, but the digestive organs are good in the main.

I believe it to be a disease of the nerves, call it neuralgia, & several other gentlemen have given it the same title. But this is not relieving the patient. The subject of this has an unblemished character, is intelligent, and has received a liberal education. Now if you will give me your opinion and suggest some treatment in the case, you will ever command in my regard & esteem.

John Thomas Pritner

Letter 7. W. C. Haymond to Samuel Jackson, Fairmount, Va., 12 September 1848.

Sir:

I am 45 years old, enjoyed better health than is usual [until] February 1847, when I was attacked with epilepsy while arguing [with] a cousin in court — a disease which I had then thought but little about, and my attention was not directed to it until 5 months after, at Saratoga Springs, at which time and place I had a second paroxysm, in the course of four weeks, a third, and then in about eight weeks, two, and about the same time, three in half-hour intervals, then seven twice, until after those 7 the second time, they was all called severe. They have since become lighter and, recently, of shorter intervals, and generally but one now at a time, after which I have some pain in the head, vomit, and feel restless for a few hours, after which I can get up and go about as usual. I have always had the paroxysms to continue until this disturbance of the head & stomach, which has induced me to believe it there that the disease is located.

I have slight pains occasionally in my legs, feet, shoulders, etc., frequently look sallow complected and ghostly a few days preceding an attack, but usually well at the time. My nose has ached for many years every few days to such a degree that I would have to rub it with all my strength for a few minutes for the last three months. The membrane which lines the

inside of that member has been inflamed and ulcerating in its appearance and so continues. My lips also frequently ache of late. My neck is frequently slightly affected something like what is called a crick in the neck. I have had the piles for many years. They are not any worse than I know of those formerly. I sometimes have some pain in the small of my back before attacks.

I am stout, 6 feet high, and usual weight 155 since grown, and that is now my weight. Have been fond of strong diet and used tobacco to a great excess for 25 years; quit entirely about 14 months since. Have used spirits moderately. Took nitrate of silver for 4 months for this disease and have used a cold shower bath for 12 months and now using it and taking Jones's Sedative Pills every day to keep my bowels open. I have all my life been inclined to be costive.

I have been advised to call upon you for your advice and treatment should you think my case one that could be likely reached by medicine or other treatment. I have given you the outlines of the case and would desire to know whether you think you can cure me or not and if it would be of any advantage for me to visit Philadelphia. If so, I will come on there in the month of October. I have no idea of what your fee for advice will be, but will send it to you when I hear from you or should you desire me to be there in person, I will bring you the fee. Please inform me in either case what it will be.

Yours respectfully,
W. C. Haymond

Letter 8. W. C. Haymond to Samuel Jackson, Fairmount, Va., 3 November 1848.

Dear Sir:

On the day before I arrived at home, I had a return of my paroxysms, and four days afterwards, I was again attacked, at which time I had two at intervals of five hours, which is very near if not precisely like I was attacked before I started and while on my way to Philadelphia. My health otherwise is about as it has been. You will recollect that I mentioned to you that I had been troubled for 20 years with an aching of the nose and that I had latterly felt some little aching and singular feeling in my upper lip. On one occasion, a few days since, that feeling and aching of the lip developed itself more fully by my said lip swelling in a few minutes to double its usual size, which swelling in the course of five hours entirely abated, and things appeared as before. I know that the swelling was not from any local cause. If not, can you account for it without worms? I should be glad to know.

I still continue the powders and diet as you directed. Can I with safety add beef soup and butter or either of those articles to my diet?

I hope you will inform me soon in relation to the above. I am not disposed to be troublesome and am willing to compensate you at any time for your services.

Am respectfully your obedient servant,
W. C. Haymond

Letter 9. Francis H. Deane[10] to Samuel Jackson, Richmond, Va., 4 December 1848.

Dear Sir:

Although a stranger, I take the liberty of addressing you a few lines, feeling you will readily excuse me.

I have under my care an interesting young woman who is desirous to have your opinion concerning her case. An uncle of hers & perhaps other relatives who were under your care some years ago & who thought they were greatly benefitted makes her peculiarly solicitous to have your advice.

Her age is seventeen, menstrual flux commenced when she was only twelve, has occurred regularly ever since. Bowels rather inclined to constipation. General appearance of the patient indicates perfect health, spirits always good, mind unimpaired. At the age of fourteen, was seized with spasms. These have continued almost uninterruptedly ever since. Periodicity does not exist; sometimes they will occur every 2 or 3 days or weeks. Until within the last 11 months, the interval between them was never longer than 2 or 3 weeks. Within the last 11 months, she had an exemption for nine months. This occurred whilst she was under no particular treatment. The only circumstance worth mentioning is the fact that about twelve months ago, she was residing in Mississippi & since has resided in this city. This exemption had existed for six or eight weeks before she left Mississippi, so I am unable to say what result to ascribe to change of climate.

She has used setons, taken zinc, iron, etc., etc. Since she has been under my care, I have not directed any specific treatment, merely used remedies calculated to promote her general health. The nitrate silver had never been tried. The health of the patient is so good I have thought possibly marriage might relieve her symptoms. To this she objects from motions which will readily suggest themselves. She desires me to say that if you feel you could relieve her, she would take up her abode in your city, although it would be accompanied by expenditures she could not very well afford.

I hope, sir, you are well & in the enjoyment of a large portion of this earth's happiness. Whilst I never had the pleasure of any other acquaintance than the casual one that sometimes takes place between professor & stu-

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10. Francis H. Deane (d. 1870), M.D. University of Pennsylvania, 1832, Richmond, Virginia, practitioner.

dent, yet I have for you a feeling that I can call by no other name than the sacred one of friendship.

Respectfully & truly,
Francis H. Deane

Letter 10. W. C. Haymond to Samuel Jackson, Fairmount, Va., 1 February 1849.

Dear Sir:

I wrote to you some time since, informing you that I had stood up under one of my attacks and retained my reason. Have not heard from you since.

Since that time, I have had two very light ones in which I lost my reason, & one of them was night before last, and on yesterday, I had three, and today, two of those attacks without losing my reason, and keeping my feet all the while. I do not understand this aspect of the disease and thought it prudent to apprise you of this change.

Upon yesterday, when I had those attacks, I did not jerk very much, felt cold as they went off, and afterwards my pulse was regular, when they were on, say at about 70, little slower and softer after they were off. My heart fluttered considerable while those spells were on. Those spells are in all respects like those with which I was originally attacked, except that I am able to stand up and retain my reason, which, by the by, is considerable. I have thought it advisable to inform you of this change the disease was about making apparently. Have you ever had a case like this before, as it seems to me now that the treatment might now require a change? I shall be glad to hear from you.

Yours respectfully,
W. C. Haymond

Letter 11. A. F. Gregory to Samuel Jackson, Austinville, Va., 4 February 1849.

Dear Sir:

This is to inform you that since I adopted your prescription given to me last fall, my general health has been much better than it had been for the year previous. Notwithstanding, I have had three paroxysms since the 1st October last, neither of which have been as severe as usual. The last I had was on last night about 8 o'clock which lasted but a few minutes. I had been in dread of this attack from Tuesday the 30th ultimo, as from that day I had been a good deal afflicted with colic. My diet since I had the pleasure of seeing you has been macaroni, mush, rice, bread, and milk,

and I have taken two of the powders daily which you directed me to take. Since I have been taking the powders, I am subject to colic, to which I was not before, whether it is owing to the effect of the powders or not I cannot say. Doctor Sanders, one of the physicians of the neighborhood who prepared some of the powders, says not. In consequence of the coldness of the winter here, I have not taken the shower bath. Another reason is that I have been much affected with a cold this winter but had no cough. The attack which I had last evening may have been produced from eating a small piece of fresh venison, which was very tender, for dinner, or taking some tea for supper with a view of it stimulating me and relieving me of the pain in the bowels and stomach, instead of milk which is my usual beverage.

I am not near so much affected with giddiness of the head as I was before I commenced using your prescription, nor am I so much affected with the glimmering before my eyes. When affected with colic, I am afraid to take any stimulant, fearing it may affect my head.

You will much oblige me be instructing me whether I am to continue the use of the powders as usual when I have the colic or not. I will call to see you again next spring, if you consider it necessary, but if not, I had rather avoid the fatigue of the journey to your city.

Any suggestions in relation to my future course will be thankfully received by your

Obedient servant,
A. F. Gregory

Letter 12. W. C. Haymond to Samuel Jackson, Fairmount, Va., 19 February 1849.

Dear Sir:

I had expected to have heard from you before this. My two last letters informing you of a very considerable change apparently in the character of my disease has been entirely unanswered. Since I wrote to you last, say in about ten days after, I had two slight symptoms of an attack that caused me involuntarily to rise to my feet. A drink of water and walk across my room would entirely restore me. I then had one that caused me to sink to the floor under a violent shaking, like an ague, no jerking. I was conscious after I was on the floor, and it is a matter of doubt amongst who were present whether I lost my consciousness or not. I was only down about a minute. The same night I felt another very slight symptom which passed off without my getting entirely up, and about ten days since, I had another slight symptom or attack which is the last one I have had. That was so slight that a gentleman who was conversing with me did not discover it. My heart flutters very much at those times and pulse is tolerably good yet

a little weak and fast in a short time after they pass off. My heart flutters a little at other times occasionally and seems to labor. I have an increase of urine a great proportion of the time, but little colored, occasionally a small quantity highly-colored. My appetite has been and is good.

I have not had any pain in the head or sickness at the stomach since I wrote to you. You will recollect I told you that my spells was always followed by sickness of the stomach and violent headache. This has happened but once since I left Philadelphia. I should like to have your opinion of my case under this view of it and would like to know whether you consider my stomach diseased or not. You need not refrain answering for fear of changing my habits in relation to diet. I shall not do so.

Yours respectfully,
W. C. Haymond

Letter 13. Edmund P. Taliaferro[11] to Samuel Jackson, Orange, Va., 30 December 1849.

My dear sir:

Permit a disciple of yours, who attended a summer course of lectures in '33 and graduated the following winter, to express his gratitude for the information obtained at your hands and now, in the time of need, to call upon you again, believing you will do all in your power to relieve suffering humanity.

I married in '37 and have seven children. My lady was healthy, but of a nervous temperament. In the fall of 1846, while she was in the family way, she had an attack, as I thought, from what I could learn, of hysteria, for I was not at home. That was followed by a severe attack of typhoid fever, which was prevailing with us at that time.

In the fall of 1848, she was far advanced in pregnancy, and her mind was greatly disturbed, in consequence of a difficulty which her brother had with his neighbor. The result was she was jumping and catching frequently in her sleep and complained of her head frequently. At length, she was taken suddenly with a convulsion and fell on the floor, deprived of sense and consciousness. It was soon over, and she did not have another until sometime after her confinement. She has had them irregularly since, sometimes once a fortnight, then again a month. She was confined about three months since. After that, she had no attack for three months and four days. Several times she has had a second paroxysm a few hours after the first.

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11. Edmund P. Taliaferro, M.D. University of Pennsylvania, 1834, Virginia practitioner.

She has been taken generally in the night, but several times in the day. After the paroxysm, she is dejected and low-spirited for several days, disposed to weep.

I have never seen a case of epilepsy before, though I believe her case comes under that head. I have been called to Mr. Quintus Barbour,[12] who you have been attending, but never saw him in a paroxysm.

I was in hopes my lady's was more hysterical, as they occurred during pregnancy, and she was naturally more nervous, though remarkably healthy and possessed a fine flow of spirits. She compares her feeling, just before an attack, to water rushing over a dam and sometimes complains of ringing in her ears. At first, she was satisfied her memory suffered, but, of late, I have not discovered it. She has a remarkably fine memory, never forgets dates, etc.

The paroxysm lasts a few minutes. Her face is generally drawn (I should have said, always to the right) and her tongue suffers if not protected by putting something between her teeth. She sleeps then for several hours, then rises and complains of weakness, but goes about her ordinary occupation, for she is naturally inclined to be industrious. She complains of sickness of stomach after each attack and, frequently, of pain in her womb and, lately, of difficulty in retaining her water.

She has been always so healthy that I have been unable to restrict her to a regular diet. I have tried counter-irritation to the nape of neck (tartar ointment) and cupping the temples and tinctura digitalis, valerian, etc., to quiet nervous irritation and mild cathartics for the bowels — without any apparent effect.

It rests with you, my dear sir, with your extensive experience, to lay down some plan or suggest what you think most advisable under the circumstances. I have not tried nitrate of silver; what is your experience with it?

I liked to have forgotten to add, her attacks occur oftener at the full and change of the moon, than otherwise.

I believe I have given you an accurate description of her case; I must conclude, hoping and believing I shall hear from you soon and that you will do all in your power to relieve the affliction of one that is near and dear to me.

Very respectfully your friend,
Edmund P. Taliaferro

She is tall, neck longer than usual, and weighs about one hundred & twenty.

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12. A letter from Quintus Barbour to Samuel Jackson is included in the collection.

Letter 14. John Seibert[13] to Samuel Jackson, Johnsville, Ohio, 6 January 1851.

Dear Doctor:

Having lately had a number of cases of epilepsy in children to treat, and being disappointed in the various remedies usually laid down in books for this complaint, such as camphor and opium, nitrate of silver, etc., I should, however, state that while I resided in Maryland, I administered the extract of stramonium, with effect, in epilepsy, but the symptoms resulting from its use were of such a terrible character that I have since abandoned its use in this disease, and I thought that from your extensive book and practical knowledge, you might possible suggest a more effectual remedy.

Any information communicated will be kindly and thankfully received by your old pupil and admirer.

John Seibert

Letter 15. Virginius W. Harrison[14] to Samuel Jackson, City Point, Va., 2 July 1854.

My dear sir:

It becomes my duty to consult you in reference to a case of disease in the person of a sister of mine, aged 13 years. For two years or more, a disease seems to have been working insidiously upon her system, which at first was very lightly regarded, but at present, with apprehensions of an unfavorable issue. The disease, we fear, is epilepsy. Two years ago, she was observed to stop suddenly, when actively engaged at play, with a vacant stare and seemed perfectly unconscious of and indifferent to all passing around her. She would appear perfectly calm, features in no way distorted, though perfectly destitute of consciousness. This state would last not more than a minute, when she would continue in her amusement as if nothing had happened. This would occur very seldom at first, but more frequently at present, several times during the day. Should she become confused in her ideas — suddenly alarmed or excited — this state of mind is very apt to make its appearance.

About 3 months since, she had purpura, which soon yielded to treatment. At this time, she is rather anemic. A few days since, she had a decided convulsion before recovering from sleep, early in the morning, at least no one was cognizant of her having been aroused from her slumber previous to its occurrence. It lasted about fifteen minutes. She complains of pain

13. John Seibert (d. 1896), M.D. University of Pennsylvania, 1845, Chicago, Illinois, practitioner.

14. Virginius Williams Harrison (1829–1879), M.D. University of Pennsylvania, 1851. Harrison was a Confederate Army surgeon during the Civil War.

in the epigastrium frequently attended with nausea, though seldom with vomiting, occasionally with fullness about her head. She is quite anemic, though she has taken the preparations of iron for some time. She was cupped soon after the convulsion passed off. She is still taking iron and uses the cold bath and wet bandage around her body daily. She is naturally of a lively disposition, sprightly mind, and very fond of study. The day before she had the convulsion, she had eaten a portion of cucumbers for dinner.

I would be very grateful, my dear sir, if you would write me your views about the case, as regards its nature and treatment. Perhaps you may have forgotten me. I was a pupil of yours in 1850–1851 and a graduate of the University of Pennsylvania.

Hoping this may find you well, I remain,

Yours very truly,
Virginius W. Harrison

Historical Collections
College of Physicians of Philadelphia
19 South 22nd Street
Philadelphia, PA 19103

Report of the President of the College of Physicians of Philadelphia at the Annual Meeting of the Fellowship, 26 November 1991

DANIEL L. SHAW, JR.

Fellows of the College of Physicians of Philadelphia, it is a privilege to share with you the Report of the President for 1991. It has been a year of substantial accomplishment for the College, building on past achievements and made possible by hundreds of loyal and generous supporters who value, as I do, the contributions of the College to medicine and to the community.

The theme of my report to you a year ago focused on what I called "infrastructure." Broadly speaking, we have concentrated our efforts over the five years that began this institution's third century with securing our foundations. By restructuring the way we govern and manage this institution, improving our operational and fiscal controls, and establishing programs for fund development and member relations, we have significantly strengthened the College's ability to recoil undamaged from pressure or shock. That is, we have in good measure institutionalized resilience. Thus encouraged and fortified, the College begins the next five years in an effort to enhance its relevance. The College's programs must be made more relevant to its Fellowship, the medical and health care communities, and the public. In the report that follows, I should like to describe the progress of these pursuits and briefly to point to plans which will be improved by your advice and ultimately fulfilled with your continuing support.

Allow me now to report to you on the accomplishments of the past year with respect to operations. Last year the College's governance completed its first year under its new system of quarterly meetings of the Council, monthly meetings of the Executive Committee, and regular meetings of five standing committees. I am gratified to report that this arrangement has improved the coordination of business, intercommunication among our volunteer leadership and between governance and management, and oversight of the College's operations. This year, according to schedule, we have

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begun the process of creating special committees to carry out institutional objectives by means of voluntary efforts of our Fellows. Under the guidance of the Committee on Development, chaired by Dr. Frederick Murtagh, a group of volunteers has been assigned to help fulfill the goals of the College's new planned giving program. Under the auspices of the Committee on Fellowship, chaired by Dr. Edward J. Resnick, a new Fellowship Enhancement Committee has been created to identify and help recruit the most promising candidates for College Fellowship and to assist the College's leadership in determining ways of enriching the Fellowship experience. This network of workers will be led by Dr. Wallace G. McCune.

Fund development and Fellowship enhancement are keys to institutional stability. I am pleased to report that in Fiscal Year 1991 the College inducted 179 new Fellows. Currently 2,067 members strong, the Fellowship of the College stands at an all-time high, though still fewer than our mandated ceiling of 2,500 members. Also in Fiscal Year 1991 the College received over $524,062 in new gifts and pledges. This includes a record $150,474 in annual gifts from 625 donors. It does not count another $394,649 received during the year as payments on pledges to the successful New Century Fund campaign. The new planned giving program, alluded to earlier, represents an effort not only to secure the future of the institution by enhancing its endowment and strengthening its programs but also to provide the Fellows with immediate, tax-wise vehicles for improving their own investment and estate planning. For this mutually beneficial program, we have retained the services of a consultant to complement the College's volunteer and professional energy and expertise. Already several gifts have been and are being structured that will repay many times over the College's investment in this program. We continue to receive gifts to endow subscriptions to journals in our Library under the auspices of the S. Weir Mitchell Program and we encourage additional commitments to the program in order to meet the Library's needs. A new and needed initiative to organize a group of friends of the Library's Historical Collections, each of whom pledges $1,000 annually for the purchase of special materials, has had an auspicious beginning. The Samuel Lewis Circle already has 14 members.

Internally — operationally — the College continues to manage its affairs with diligence. Thanks to our increased capacity to enhance revenue, control costs, increase efficiency, and maximize productivity, the College's financial performance surpassed its budgeted

projection by $35,611 last year. This achievement continues a favorable four-year trend. This year, for the first time in recent memory, we project a balanced budget.

Currently, the College is in the midst of two exercises which typify and, in a way, culminate the five-year effort to rationalize the way the institution operates. First, a state-of-the-art computer system is being installed and programmed to drive our operations efficiently and effectively. Second, we are constructing the first business plan in the College's history. Called the Three-Year Plan, it will attempt to predict and define with as much precision as possible the activities of the College of Physicians of Philadelphia over a period beginning 1 July 1992 and ending 30 June 1995. It will serve as a management and assessment tool to help us achieve utilization and proper allocation of our resources in fulfillment of the College's institutional mission.

What is most gratifying to me in reviewing such progress is the way in which governance, management, and dedicated volunteers have conspired to achieve results. In the area of institutional enhancement, the committees of Development and of Fellowship work closely with the Office of Institutional Advancement, headed by A. Jerry Condon. In the area of institutional operations, the committees of Administration and of Finance cooperate effectively with the newly reorganized Office of Finance & Accounting, administered by Benjamin Pierce. Chaired by Dr. William C. Frayer, the Committee on Administration last year provided critical oversight and valued advice as the College constructed a new employee benefits package and a new personnel policies manual and employee handbook. The way we select, train, manage, compensate, and reward our employees is directly related to the productivity, stability, and success of our organization. I am proud to say that the new package offers the staff more benefits, but at less cost to the College, than the former plans. Our ability to create our employee handbook in-house saved tens of thousands of dollars. This year the Committee on Administration is concentrating on the establishment of a long-sought capital needs assessment plan and program.

The Committee on Finance, chaired by Dr. Charles T. Lee, Jr., has provided excellent oversight of the reorganized financial operations of the College. Working with the Investment Committee, it has refined our investment policy. It has devised a spending rule that allows the College to respond flexibly to long- and short-term needs. Its leadership role in establishing a balanced budget reflects

the effective collaboration and cooperation of governance and management.

Assisting both management and governance is the College's Board of Advisors, chaired by John W. Eckman, L.H.D. I cite with particular thanks the efforts this past year of two key advisors: Philip A. Metcalf and Philip W. Young. Respectively, they provided invaluable advice to the College in the critical areas of computer reconfiguration and investment performance analysis. Finally, I must acknowledge the individual who orchestrates this complex symphony, our executive director John M. O'Donnell, whose commitment, enthusiasm, and leadership have made a difference.

It is safe to say that our sails are trimmed and it is important now to concentrate on where we are bound and with what cargo. Dr. Robert H. Bradley, Jr., chairs the Committee on Program, which is largely responsible for navigation. Its function, as I shall quote from the By-Laws, is large: "The Committee on Program shall oversee and evaluate the functioning of all aspects of the College's relations with the Fellowship, clients, and other constituencies in the medical community and the larger public as transacted through the College's Library, Mütter Museum, Francis C. Wood Institute, Committee on Public Health, and programs of lectures, publications, and awards." That is a sizeable responsibility.

Our Library, co-directed by Andrea Kenyon (Public Services) and Thomas Horrocks (Historical Services) remains a powerful resource of biomedical information, contemporary and historical, for the region and the nation. Locally, our library is the major net lender of information. As an Area Resource Library of the National Library of Medicine's Regional Medical Library Program, it is the region's primary resource. During the first six months of this year, to cite one example, the College loaned via this network in excess of 22,000 articles, followed by the New York Academy of Medicine with 16,000 loans, and the University of Massachusetts with 10,000 loans.

As a founding member of the Health Sciences Libraries Consortium (HSLC), it is helping to build a nationally replicable model for the rapid and economical delivery of biomedical information. As a participating member of the Philadelphia Area Consortium of Special Collections Libraries (PACSCL), it received last year a three-year grant totalling $162,526 from the Pew Charitable Trusts for processing and cataloging rare works and manuscripts in the Historical Collections of the Library. Last month, the College's Council

approved the Collection Development Policies of the Library and the Museum, a massive effort to relate the goals of these divisions to those of the institution, to provide a rational basis for collection decisions, and to indicate to the outside world our strengths and direction.

In May, the Wood Institute sponsored a major conference on a contemporary health care issue, that of medical malpractice reform. The conference, "Seeking Common Ground: Law, Medicine, and Patient Care in the 1990s," was the culmination of a year-long Law and Medicine Project that involved doctors, nurses, insurance executives, judges, legislators, and policy scientists. Its success increased the visibility of the College not only in the health care community but also in the legal and legislative arenas.

Institute director Caroline Hannaway recently received a grant of $85,000 from the National Endowment for the Humanities to research and hold a conference at the College on the "History of Scientific Medicine in Paris, 1790–1850." The conference is planned for 21–22 February 1992.

The excellence of the College's resources is matched by that of its staff, as indicated by their professional standing among their colleagues. During the past year, Andrea Kenyon served as president of the Philadelphia Chapter of the Medical Library Association; museum director Gretchen Worden was president of the Museum Council of Philadelphia; Thomas Horrocks was a member of PACSCL's Executive Committee; Caroline Hannaway chaired and served on numerous committees of the National Library of Medicine and of the American Association for the History of Medicine; and John O'Donnell presided over HSLC's Board of Directors.

In the coming years, as will be evidenced in the College's Three-Year Plan, we shall attempt to fulfill two principal goals for our programs: first, to put them more rigorously in service to our institutional mission; second, to create synergy among them. For example, one aspect of the College's mission is "to contribute in all appropriate ways to the health of the community." One way of doing this is by supporting comprehensive health education in the region and specifically within the schools. Under the leadership of Dr. Robert G. Sharrar, chairman of our Committee on Public Health and Preventive Medicine, the College and the School Board of Philadelphia have jointly impaneled a planning committee composed of representatives from the College and the School District in an attempt to

develop a community coalition in support of the District's health education initiatives.

It is clear that the public perceives the College as a potentially strong advocate on health and health policy issues. We are taking this role seriously in our planning. In addition to our role as advocate, we are discovering that we have many resources with which to support health education. Our Library's vast resources, particularly its state-supported Health Information to Pennsylvania Residents Program, can be put at the disposal of health educators. The Mütter Museum can become a powerful laboratory for health education projects. In fact, the Museum has recently submitted a grant proposal to the Howard Hughes Medical Institute in the amount of $382,776 to expand the Museum's program for schools' field trips, to build a program of anatomical study, to provide student internships, to collaborate on education and career orientation projects with a health science magnet school, and to help teachers enhance their health and science curricula. The College has recently "adopted" a Philadelphia public school and, under the auspices of the Committee on Public Health, is laying the groundwork for a guest speakers program on such topics as substance abuse, disease prevention, nutrition and fitness, and other topics of vital concern. A portion of our College lecture program is being dedicated to a discussion of health issues facing our community.

In short, we have begun to realize that, by using our full range of institutional resources, we can make an impact. In the coming months and years, we shall be setting our direction, outlining our plans, and encouraging your recommendations and participation. What we offer you today is a report and also a vision, a vision that — when realized — will make this next 10 years one of the most productive decades in the College's history.

My thanks to those who have helped to bring us within striking distance of this vision and my best wishes to those who have the talent, the will, and the perseverance to see it fulfilled.

New Books In the History of Medicine in the Historical Collections of the Library, July to December 1991

JACK ECKERT

Alain Besson, ed., *Thornton's Medical Books, Libraries, and Collectors: A Study of Bibliography and the Book Trade in Relation to the Medical Sciences,* third revised edition (Aldershot, England, and Brookfield, Vt.: Gower Publishing, 1990).

James H. Cassedy, *Medicine in America: A Short History* (Baltimore, Md.: Johns Hopkins University Press, 1991).

David Y. Cooper III and Marshall A. Ledger, *Innovation and Tradition at the University of Pennsylvania School of Medicine: An Anecdotal Journey* (Philadelphia, Pa.: University of Pennsylvania Press, 1990).

Francesco Cordasco, *Homeopathy in the United States: A Bibliography of Homeopathic Medical Imprints, 1825–1925* (Fairview, N.J.: Junius-Vaughn Press, 1991).

Jacqueline Karnell Corn, *Environment and Health in Nineteenth-Century America: Two Case Studies* (New York: Peter Lang, 1989).

Paul F. Cranefield, *Science and Empire: East Coast Fever in Rhodesia and the Transvaal* (Cambridge: Cambridge University Press, 1991).

J. Worth Estes, *Dictionary of Protopharmacology: Therapeutic Practices, 1700–1850* (Canton, Mass.: Science History Publications, 1990).

John Farley, *Bilharzia: A History of Imperial Tropical Medicine* (Cambridge: Cambridge University Press, 1991).

Emil J. Freireich and Noreen A. Lemak, *Milestones in Leukemia Research and Therapy* (Baltimore, Md.: Johns Hopkins University Press, 1991).

Faye Marie Getz, ed., *Healing and Society in Medieval England: A Middle English Translation of the Pharmaceutical Writings of Gilbertus Anglicus* (Madison, Wis.: University of Wisconsin Press, 1991).

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Victoria A. Harden, *Rocky Mountain Spotted Fever: History of a Twentieth-Century Disease* (Baltimore, Md.: Johns Hopkins University Press, 1990).

Ernest Heberden, *William Heberden: Physician of the Age of Reason* (London: Royal Society of Medicine Services, 1989).

Christopher Hoolihan, compiler, *An Annotated Catalog of the Miner Yellow Fever Collection* (Rochester, N.Y.: Edward G. Miner Library, University of Rochester School of Medicine and Dentistry, 1990).

John F. Hutchinson, *Politics and Public Health in Revolutionary Russia, 1890–1918* (Baltimore, Md.: Johns Hopkins University Press, 1990).

Janice M. Irvine, *Disorders of Desire: Sex and Gender in Modern American Sexology* (Philadelphia, Pa.: Temple University Press, 1990).

Lily E. Kay, *Molecules, Cells, and Life: An Annotated Bibliography of Manuscript Sources on Physiology, Biochemistry, and Biophysics, 1900–1960, in the Library of the American Philosophical Society* (Philadelphia, Pa.: American Philosophical Society, 1989).

Johannes de Ketham, *The Fasciculus Medicinae of Johannes de Ketham, Alemanus,* trans. Luke Demaitre (Birmingham, Ala.: Classics of Medicine Library, 1988).

Pearl Kibre, *Hippocrates Latinus: Repertorium of Hippocratic Writings in the Latin Middle Ages,* revised edition (New York: Fordham University Press, 1985).

Lester S. King, *Transformations in American Medicine from Benjamin Rush to William Osler* (Baltimore, Md.: Johns Hopkins University Press, 1991).

Susan E. Klepp, *"The Swift Progress of Population": A Documentary and Bibliographic Study of Philadelphia's Growth, 1642–1859* (Philadelphia, Pa.: American Philosophical Society, 1991).

Ruth Leys and Rand B. Evans, eds., *Defining American Psychology: The Correspondence between Adolf Meyer and Edward Bradford Titchener* (Baltimore, Md.: Johns Hopkins University Press, 1990).

Floyd Matson, *Walking Alone and Marching Together: A History of the Organized Blind Movement in the United States, 1940–1990* (Baltimore, Md.: National Federation of the Blind, 1990).

Pauline M. H. Mazumdar, ed., *Immunology, 1930–1980: Essays on the History of Immunology* (Toronto: Wall & Thompson, 1989).

Deborah Kuhn McGregor, *Sexual Surgery and the Origins of Gynecology: J. Marion Sims, His Hospital, and His Patients* (New York: Garland Publishing, 1989).

Carol L. Moberg and Zanvil A. Cohn, eds., *Launching the Antibiotic Era: Personal Accounts of the Discovery and Use of the First Antibiotics* (New York: Rockefeller University Press, 1990).

David B. Morris, *The Culture of Pain* (Berkeley, Calif.: University of California Press, 1991).

Emily J. Oakhill, *A Survey of Sources for the History of Nursing and Nursing Education at the Rockefeller Archive Center* (North Tarrytown, N.Y.: Rockefeller Archive Center, 1990).

Philip R. Reilly, *The Surgical Solution: A History of Involuntary Sterilization in the United States* (Baltimore, Md.: Johns Hopkins University Press, 1991).

David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991).

William Schupbach, *The Iconographic Collections of the Wellcome Institute for the History of Medicine* (London: Wellcome Institute for the History of Medicine, 1989).

Melissa A. Smith, compiler, *A Survey of Sources for the History of Child Studies at the Rockefeller Archive Center* (North Tarrytown, N.Y.: Rockefeller Archive Center, 1988).

Owsei Temkin, *Hippocrates in a World of Pagans and Christians* (Baltimore, Md.: Johns Hopkins University Press, 1991).

Marcel Tetel, Ronald G. Witt, and Rona Goffen, eds., *Life and Death in Fifteenth-Century Florence* (Durham, N.C.: Duke University Press, 1989).

Michel Valentin, *François Broussais, 1772–1838: Empereur de la Médecine* (Dinard, France: Association des Amis du Musée du Pays de Dinard, 1988).

Reviews

PHILIP R. REILLY. *The Surgical Solution: A History of Involuntary Sterilization in the United States.* 165 pp. Baltimore, Md.: Johns Hopkins University Press, 1991. Price $19.95.

Reviewed by LEILA ZENDERLAND

Between 1907 and 1960, more than sixty thousand Americans were subjected to surgical sterilization, nearly all without their consent and many even without their knowledge. Most of these operations took place in institutions for the mentally retarded or mentally ill, or in prisons. Their purpose, according to doctors promoting them, was largely social: to prevent the birth of additional members of the "defective, dependent, and delinquent classes." In *The Surgical Solution: A History of Involuntary Sterilization in the United States,* Philip Reilly, a physician and lawyer, has traced the history of this movement. By examining a wide range of archival sources, he has documented one of the most alarming chapters in contemporary medical history.

Reilly begins his study by examining the belief, widely held in the late nineteenth and early twentieth centuries, that not only "feeblemindedness" and insanity but also criminality, promiscuity, and pauperism were inherited conditions. Within this context, the development of relatively safe new sterilization techniques such as vasectomy for men (first tried in 1897) and salpingectomy for women (first practiced in 1910) led numerous physicians and reformers to advocate a "surgical solution" for pressing social problems.

Most of this book focuses on the ensuing battles to make involuntary sterilization legal. Proponents won their first victory in Indiana in 1907, when the legislature passed "An act to prevent procreation of confirmed criminals, idiots, imbeciles, and rapists." Various statutes legalizing sterilization were eventually passed by about two-thirds of the states. Among these were Virginia's 1924 law authorizing physicians to sterilize the "potential parents of socially inadequate offspring" and Oklahoma's 1935 "Habitual Criminal Sterilization Act."

Reilly's account relies heavily on the emergence of the eugenics movement in explaining both the origins and the dissemination of

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these beliefs. While this was largely true in the twentieth century, it overlooks the strong influence of older medical theories which actually preceded and helped shape eugenic ideas. Among these, for instance, were the highly influential theories linking physical with moral "degeneration" produced by Dr. Benedict Morel in the nineteenth century.

This shortcoming is more than offset, however, by Reilly's original analysis of this movement's twentieth-century history. His book offers a detailed exploration of state and national policies, legal arguments and court decisions, well-organized and well-financed lobbying efforts, and equally determined counter efforts to block them.

As a result, the history of sterilization emerges less as a single movement than as a complex series of victories and defeats experienced largely at the state and local level. Proponents won numerous legislative victories in the first two decades of this century, only to see many of them quickly overturned in state courts. New laws reemerged in the 1920s and were affirmed by the U.S. Supreme Court in 1927. The number of operations peaked in the 1930s, when the Depression added an even stronger impetus for these medical practices justified as a means of curtailing welfare spending. They declined again during World War II, however, largely due to a shortage of available surgeons.

Reilly also traces the work of scientists who challenged and finally discredited this movement, both before and especially after the war, when it became associated with similar practices conducted on a far more massive scale in Nazi Germany. Nonetheless, involuntary sterilizations continued, this study proves, in the postwar decades, albeit with less publicity.

Bringing his study up to the present, Reilly explores several contemporary legal controversies. Here ironies abound, for recent court cases have focused largely on an individual's right to be sterilized. Such suits often involve parents trying to protect mentally retarded daughters from harmful pregnancies. In this area of medical practice, stringent legal safeguards are needed, the courts have argued, precisely because, as one judge declared, this subject had such a "sordid history."

By tracing this history in a clear and concise manner, Reilly has contributed an extremely important and timely chapter to the larger story of scientific attempts to understand and control knowledge of reproduction. His book offers a fascinating, frequently ap-

palling, and above all chastening lesson about the ways that modern surgical advances have proven socially dangerous as well as beneficial, and about the essential interconnections between medical practice, social policies, and human values.

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EMIL J. FREIREICH and NOREEN A. LEMAK. *Milestones in Leukemia Research and Therapy.* 195 pp. Baltimore, Md.: Johns Hopkins University Press, 1991. Price $60.00.

Reviewed by JACALYN DUFFIN

Two hundred years ago, leukemia was unknown. Fifty years ago, it was recognized as the most rapidly fatal of human diseases. In July 1991, the *New England Journal of Medicine* published an article on the health of offspring born to former chemotherapy patients, some of whom had been cured of childhood leukemia.[1] Clearly, radical changes in the medical understanding of the various forms of this disease have occurred in the recent past; however, until now, there has been no review of these achievements. Leukemia researchers Emil J. Freireich and Noreen A. Lemak initially planned to fill the void with an article, but their work quickly expanded into this welcome book *Milestones in Leukemia Research and Therapy.* As the title suggests, the purpose of this volume is not "history"; indeed, the only secondary source cited is Edward Shorter's *The Health Century* (New York: Doubleday, 1987). Instead, the authors present the evolution of major changes in the concept and treatment of leukemia. With their intimate understanding of the disease, the clarity of their presentation, and the judicious use of citation from original articles, they succeed splendidly.

In 1845, Rudolph Virchow and J. Hughes Bennett engaged in a priority dispute over their near simultaneous descriptions of leukemic patients. Virchow gave the disease its name and his description of the pathogenesis more closely approximates the current

1. Daniel M. Green, Michael A. Zevon, Geoffrey Lowrie, Nina Seigelstein, and Brenda Hall, "Congenital Anomalies in Children who Received Chemotherapy for Cancer in Childhood and Adolescence," *New England Journal of Medicine,* 1991, *325*:141–146.

view. The sinister prognosis of this newly recognized disease quickly became all too plain. At first, varieties of leukemia were identified on anatomical grounds (e.g., splenic, lymphatic, and myelogenous); later, leukemia diagnosis shifted to accommodate advances in microscopy and cell biology. Factors affecting incidence, including the 1945 atomic assault on Japan, as well as past and contemporary notions concerning causation are presented, from radiation to viruses and oncogenes. The discovery and development of each of the main therapies for leukemia is succinctly explained. The relationship of this disease to its larger scientific context is addressed, with specific reference to the funding provided to American research institutions and the impact of public clamor on development of new treatments, such as interferon.

Only in the chapter on recombinant DNA and molecular analysis, does the presentation slip into a "who, when, what" style, common with many "milestone" formats. Recognizing that the content of this chapter may seem "irrelevant to leukemia" (p. 187), the authors justify its presence by stating that molecular genetics has already assumed a large role in leukemia research and that there has been no other review of these techniques.

Freireich and Lemak note that an absolute cure for all forms of leukemia would have only a tiny effect on global mortality. Nevertheless, *Milestones* makes it clear that the study of these relatively rare disorders has engaged the energies of a host of Nobel laureates and that the related discoveries have altered many aspects of biological science.

Perhaps the most significant contribution of this volume is the reference section, which stands as a well-selected bibliography of leukemia research. Graceful epigraphs, gentle humor, and illustrations enhance the work. Most photographs are portraits of leukemia researchers, with the notable exception of the first published image of a leukemia patient who died in 1862: a solemn child with massive adenopathy and a riveting gaze. This timely book is an accurate account of interest to physicians and researchers, accessible to historians, and the first step in the process of writing the long overdue history of leukemia.

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ALLEN B. WEISSE. *Medical Odysseys: The Different and Sometimes Unexpected Pathways to Twentieth-Century Medical Discoveries*. 250 pp. New Brunswick, N.J.: Rutgers University Press, 1991. Price $13.95.

Reviewed by ROBERT H. BRADLEY, JR.

Publishers rely on the public's insatiable appetite for mystery and medicine. What reader can resist a well-told detective story? Throw in a medical theme, and literary success is assured. This being so, Allen B. Weisse has produced a winner with *Medical Odysseys: The Different and Sometimes Unexpected Pathways to Twentieth-Century Medical Discoveries*. Weisse is a practiced story teller as well as a cardiologist and professor of medicine at the New Jersey College of Medicine and Dentistry. His long-time interest has been to find and report the full story behind the great medical developments of the twentieth century. This book is not fiction, but these are stories that no fiction can approach for excitement, perseverance, daring, and human interest.

In his introduction titled "How Do Discoveries Happen" Weisse observes that serendipity or accidental discovery is rare. Hard work and good luck are more often the rule. Researchers are frequently characterized in the public's mind as persons of genius, daring, and persistence, which may be so, but their work is frequently encumbered by ambition, competition, obtuse authority, politics and war, anger and danger, and money or the lack of it. Weisse also points out that many, if not most, research advances rest on principles or observations made years, decades, or even centuries before. In this respect he quotes Sir Isaac Newton: "If I have seen further, it is by standing on the shoulders of giants."

Although Weisse focuses principally on the major discoveries of this century made by such well-known workers as Fleming, Gross, Minot, Kolff, Salk, Sabin, Enders, and Gibbon, his stories also cover in depth the less famous and equally talented individuals whose work provided the foundation or impetus for the ultimate triumphs. Weisse's contemporaneous medical experience and his personal acquaintance with many of the individuals about whom he writes contribute both balance and authority to his narrative. The chapter on poliomyelitis is a case in point. In it he describes the two different approaches to the successful conquest of polio, and then adds a thoughtful essay on the complex personalities of the two men credited with this great achievement.

Medical Odysseys has 12 chapters, each devoted to progress or success in managing a particular disease or clinical problem. The book begins with mercurial diuretics, and continues through hepatitis viruses, surgery for heart disease, and the discoveries of penicillin, the artificial kidney, and the artificial heart. Weisse then pauses with an essay on negative research, or how much of what is taught is wrong. He then continues with chapters on pernicious anemia, chemotherapy, electrocardiology, poliomyelitis, immunology, and Legionnaire's disease.

In the last two chapters, Weisse writes of the proliferation of new syndromes striving for respectability which at least afford an escape route for harried practitioners in dealing with unexplainable symptoms. He concludes by reminding the reader that there are no limits to the research that needs to be done, and that although half of it may be accomplished by meticulous reasoning, the rest will be the result of blind wandering.

I recommend this book for both pleasant reading and also as a contribution to source material in recent medical history.

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ROBERT GALLO. *Virus Hunting: AIDS, Cancer, & the Human Retrovirus: A Story of Scientific Discovery.* 336 pp. New York: Basic Books, 1991. Price $22.95.

Reviewed by ROBERT G. SHARRAR

The fact that we have learned so much about AIDS in a relatively short period of time is the accomplishment of many talented and dedicated people. One of these individuals is Dr. Robert Gallo, who has written a highly personal book, entitled *Virus Hunting: AIDS, Cancer, & the Human Retrovirus: A Story of Scientific Discovery.* The author's "main intent in telling this story has been to portray the scientific process as it goes on in our time and to describe the process of discovery in biomedical research in at least one laboratory" (p. 7).

Gallo begins with a brief personal history of how he became interested in the field of medicine and in clinical research, followed by a brief history of the National Institutes of Health. The second part of the book describes the discovery of the first two retroviruses

as causes of human cancers. This section is especially interesting because it demonstrates how the scientific process and the international scientific community actually work. It shows that scientific knowledge moves forward by sharing observations and defending ideas in an open forum. In this section of the book, he describes the physical characteristic of a retrovirus and explains how it produces disease. It should serve as a primer for anyone who is interested in understanding the pathogenesis of HIV infections.

In the third section of the book, Gallo describes the events leading to the discovery of the third retrovirus as the cause of AIDS. It is of interest to note that the earliest detection of reverse transcriptase activity in an AIDS patient by Gallo's laboratory occurred in May 1982, and that a number of viral isolates were identified by the summer of 1983. Over the next several years his laboratory made significant contributions, i.e., the development of a defined immortalized cell line which could continuously produce virus, and the serologic tests to identify HIV antibodies. Researchers there also played a major role in demonstrating the molecular structure of the virus, its heterogeneity, the presence of viremia, and the fact that the virus could infect T4 lymphocytes and macrophages.

In the final section, Gallo presents his version of the science and politics of AIDS. Much of what he says is based on factual data, but he also adds his own personal interpretation of frequently asked questions about AIDS, the pathophysiology of HIV infection, the development of Kaposi's sarcoma, and the cause of AIDS. In the final chapter, he talks about what has or could be done to control the AIDS epidemic and HIV infection. This section is especially interesting because it links all of the known scientific facts into a comprehensive whole explaining how HIV causes clinical disease in humans.

In order to understand history, one has to view historical events from different perspectives. This is one man's perspective of one of the most important public health events in this century. However, this one man played a major role in developing laboratory techniques to study retroviruses in the 1970s which made it possible for medical science to isolate, identify, and study the virus that caused AIDS in the 1980s. One wonders what sort of impact the AIDS epidemic would have had on the population if it were not for the process and progress of scientific discovery described in this book. Although the book is informative, it is not always easy to follow. At times it rambles, and burdens the reader with numerous names

that are hard to remember. However, Gallo's perspective is one that should not be missed.

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OWSEI TEMKIN, trans. *Soranus' Gynecology.* 207 pp. Baltimore, Md.: Johns Hopkins University Press, 1991. Price $18.95.

Reviewed by A. DEBORAH GOLDSTEIN

The re-issue in soft cover of Owsei Temkin's *Soranus' Gynecology,* originally published in 1956, is most welcome, appearing at a time of heightened interest in both ancient medicine and women's studies. This reprint is the only English translation of *Soranus' Gynecology* currently available.

Temkin begins with an accurate assessment of the Greek physician from Ephesus, who practiced at Rome in the early second century just before the time of Galen, calling Soranus "one of the most learned, critical, and lucid authors of antiquity" (p. xxiii). The introduction reviews what little is known of Soranus, and contains a brief discussion of the major schools of medicine of his time, with emphasis on the Methodist sect to which Soranus belonged, a textual history, and an overview of the *Gynecology.* There is also a glossary of ancient names and a 30-page materia medica pertinent to the *Gynecology.*

The *Gynecology* deals with anatomy, menstruation, dysmenorrhea, contraceptives and abortifacients, pregnancy, labor and delivery (including the obstetric chair and dystocia), and care of the newborn. Soranus recognized that amenorrhea could be secondary to exercise and anticipated our modern (re)discovery of patient-assisted delivery: "one must advise her to drive her breath into the flanks . . . with groaning and detention of the breath . . . to compress [her] breath . . . [and] to strain most when [the pains] are present" (pp. 74–75).

Soranus's reasoned yet humane approach is evident throughout. The best midwife, for example, will "be able to state clearly the reasons for her measures . . . bring reassurance to her patients, and be sympathetic" (p. 6). Similarly, superstitious and unsound practices are routinely denounced. Both wine and "the urine of an innocent child" are condemned as cleansing baths for the newborn:

"we, however, reject all of these . . . the wine, because of its effluvia, causes stupor . . . and the urine, likewise, because it is ill-smelling" (pp. 82–83). Pediatricians will be intrigued further by the recognition and treatment of thrush, exanthemata, wheezing, coughing, and "flux" of the bowels.

Soranus was a prolific author whose treatises are preserved largely through the efforts of ancient translators and compilers. The *Gynecology* is one of the few texts available in the original Greek. Two physicians are responsible for recognizing the importance of the manuscript: Friedrich Reinhold Dietz, in 1830, and Franz Zacharias Ermerins, who in 1869 published an attempt to reconstitute the original. Finally, the classical philologist Johannes Ilberg published in 1927 the Greek text of Soranus's *Gynecology* in Volume IV of the *Corpus Medicorum Graecorum*. Temkin's translation is based on Ilberg's text.[1]

Soranus has not been ignored in the 35 years since the original appearance of this volume. The 1988 addition to the Budé series (Paul Burguière, Danielle Gourevitch, and Yves Malinas, eds., *Soranos d'Ephèse, Maladies des Femmes, Tome I* (Paris: Les Belles Lettres, 1988) presents the Greek text and a translation into French. The editors include the first chapter of Ilberg's Book II, re-arrange some of the rest, add 10 passages athetised by Ilberg (arguing for inclusion on the grounds of stylistic analysis), and append three essays and an extensive bibliography.

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J. WORTH ESTES. *Dictionary of Protopharmacology: Therapeutic Practice, 1700–1850.* 229 pp. Canton, Mass.: Science History Publications, 1990. Price $49.95.

Reviewed by JOHN HARLEY WARNER

The past decade has witnessed a striking growth of interest in the history of medical therapeutics, especially in the era before the experimental laboratory began to yield such recognized symbols of therapeutic success as diphtheria antitoxin, salvarsan, and insulin.

1. Some of Ilberg's text had been translated by Kenneth Scott and appeared in Herbert Thoms, ed., *Classical Contributions to Obstetrics* (Springfield, Ill.: Charles C Thomas, 1935).

Rather than dismissing earlier practices as risible or deplorable, historians have sought to understand the mentality that gave them meaning for healers and sufferers at the time. As more and more historians have endeavored to glean information from such records of eighteenth- and nineteenth-century therapeutic activity as hospital patient charts and private practice day books, they have shared the frustration of trying to master a technical language largely unspoken for more than a century, one that is often baffling to the modern clinician and cultural historian alike.

J. Worth Estes's *Dictionary of Protopharmacology: Therapeutic Practice, 1700–1850* provides a much needed guide to that language. Drawing heavily on dispensatories and textbooks, Estes has assembled information on some three thousand terms common in the Anglophone physician's therapeutic vocabulary before 1850. Most of the entries are botanical or mineral remedies that were part of the orthodox armamentarium, but important non-drug therapies (such as bloodletting, electricity, and diet) are also included, as are some sectarian treatments and patent medicines. And, as Estes aptly points out in his short introduction, there was substantial overlap between the remedies used in domestic and professional practice. For each therapeutic agent, the author defines its ingredients and preparation, explains how it was thought to affect the body, gives selected synonyms, and, sometimes, indicates how it first entered the materia medica. Throughout, he uses terms and conceptual categories that reflect the belief system of practitioners who employed these agents, and ordinarily refrains from giving the modern concepts of the drug's pharmacological effects. So too, he says little about the diseases for which each drug was recommended, a choice that recognizes the fluidity of disease entities and the doubtful legitimacy of disease-specific therapy in the early modern medical mind. Additional entries include colloquial names for certain therapeutic agents, the units of measure used in preparing and prescribing drugs, the categories by which drugs were classified (usually by action, as in the case of an emetic or a sudorific), and common abbreviations.

The usefulness of this dictionary could have been greatly enhanced by providing fuller access to the historical literature that has explored how various therapeutic agents were deployed, both in professional polemics and at the bedside. Some entries refer the reader to a list of general references, but the list is brief and reflects a highly idiosyncratic vision of the extant secondary literature: the

entry on calomel, to cite a typical example, directs the reader to two secondary works, both by Estes, whereas the reader would have been better served by additional references to articles by, among others, Alex Berman, John Haller, and Guenter Risse. This is nonetheless a very welcome volume, making readily available information that hitherto each researcher has had to track down and organize on his or her own. It belongs on the reference shelf of everyone who sets out to explore eighteenth- and nineteenth-century pharmacy and medical therapeutics.

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WENDY MITCHINSON. *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. 363 pp. Toronto, Canada: University of Toronto Press, 1991. Price $22.95.

Reviewed by RIMA D. APPLE

Wendy Mitchinson's *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* begins with the premise that "medicine and culture go hand-in-hand and that one way of discovering attitudes towards women is to examine their medical experience" (p. 7). Dealing with English-speaking Canada, the book outlines medical explanations for women's supposed physical weaknesses and ill-health, the ways doctors viewed changes in the female body over the life-span and women's susceptibility to insanity, the reactions of medical practitioners to birth control and abortion, and the creation and development of medical specialties dealing specifically with women's health concerns, namely obstetrics, gynecology, and gynecological surgery.

Canadians of the Victorian period held the idea of science in high regard. Physicians cultivated the popular view of medicine as scientific, which endowed their work with a sense of "scientific objectivity." The connection between medicine and science reinforced the interventionist side of medicine, while denying its cultural basis. For physicians and for other Canadians, men and women were different, but man was the norm and woman's complex reproductive system was the basis of all her health problems, physically,

emotionally, and intellectually. The focus on her reproductive system made woman's ill-health seem "natural" and inescapable. Physiological functions such as menstruation, pregnancy, and menopause were seen as problematical, if not pathological. Physicians recognized that social and cultural conditions caused disease in women and, not surprisingly, their views of the world conditioned their ideas of health. Thus, their criticism of contemporary fashion reveals doctors' uneasiness with modern society and the roles of modern women, in addition to their medical concerns.

The focus of the book is the second half of the nineteenth century, a period of rapid and dramatic change in the medical world. Mitchinson gives little indication of such changes when she discusses issues such as female frailty and interpretations of female physiology. Her chapters on obstetrics, gynecology, and gynecological surgery, chapters in which she skillfully uses hospital records and physicians' writings, more clearly delineate the increasing medical intervention and medicalization of women's health conditions. Early in the nineteenth century, physicians were unwilling to examine female patients tactilely or visually; by the end of the century, however, such examinations were considered necessary and commonplace. This change reflects a shift in doctor's views; as the benefits of examination and treatment became clearer, physicians no longer viewed themselves as males who needed to protect a woman's virtue, but more as professionals.

The subtitle of *Women and Their Doctors* suggests that the reader will learn not only about what male physicians thought and did, but also what female patients thought and did. (Mitchinson explains that only a minuscule number of physicians were female throughout the entire period of review.) Unfortunately, the patients are generally silent. We hear female patients almost exclusively through doctors' records and institutional reports, in which the patients are often portrayed as relatively passive victims. Mitchinson claims that women's actions helped to shape the medical care they received, but how?

Mitchinson's sources clearly show the interconnectedness of the English-speaking medical world in the late nineteenth century. The books used in Canadian medical schools were published in the United States and Britain, as well as Canada; the articles published in Canadian journals were penned by Canadians, as well as reprinted from American and British sources; physicians practicing in Canada were trained in the United States and Britain, as well as

Canada. What her study tells then is not a uniquely Canadian story, but one that deepens our understanding of the role of culture in maintaining and refining gender roles and medical experiences.

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KATHRYN MONTGOMERY HUNTER. *Doctors' Stories: The Narrative Structure of Medical Knowledge.* 173 pp. Princeton, N.J.: Princeton University Press, 1991. Price $24.95.

Reviewed by JULIA EPSTEIN

Doctors' Stories: The Narrative Structure of Medical Knowledge, by Kathryn Montgomery Hunter, offers a careful, detailed, and often brilliant ethnography of the complex intellectual processes of clinical diagnosis and clinical education. Hunter, a professor in the ethics and human values in medicine program at Northwestern University Medical School, was trained in English literature and has been a pioneer in the development of courses in the medical humanities. Hunter is a keen observer, and she brings to bear a sophisticated understanding of the nature of storytelling to her examination of the ways physicians speak to each other, teach medical students, keep records of their patients, and write up their cases. Hunter proposes that a well-developed narrative method is at the center of clinical medicine, and that physicians are "highly trained, critical readers of the text that is the patient" (p. 4).

Other scholars and physicians have been paying attention to the ways patients become cases, and have argued that diagnostic reasoning both necessarily constructs patients as objects of study, and sometimes, as a consequence, ends up objectifying patients in dehumanizing language. Hunter's work in *Doctors' Stories* complements the recent writings of Howard Brody (*Stories of Sickness* [New Haven: Yale University Press, 1987]) and Arthur Kleinman (*The Illness Narratives: Suffering, Healing, and the Human Condition* [New York: Basic Books, 1988]). While Brody focuses on literary representations of illness and Kleinman investigates the life stories of the chronically ill, Hunter turns her attention to attending physicians, residents, and medical students in tertiary care centers.

In her analysis of the variety of ways physicians communicate their knowledge to each other, she looks in turn at the functions of anecdotes, charts and case reports, and clinical-pathological conferences and syndrome letters, and applies the critical tools of narrative and historiographical theory.

Using passages from the Sherlock Holmes stories of Arthur Conan Doyle as epigraphs for each chapter, Hunter argues that "the semiotics of detection are precisely those of medicine" (p. 169). But she also goes well beyond that analysis of clinical reasoning, calling for a "richer narrative than the traditional medical case" (p. 149) in "this era of chronic, environmentally induced, and psychosomatic illness" (p. 128). The most exciting section of this fine study comes in a chapter that uses the example of the Bororos of South America, who believe that they become red parakeets at their death. Anthropologists have appealed to this example as "an epitome of the incommensurability of our discourse and theirs" (p. 124). Hunter asserts that there is also a fundamental and inevitable incommensurability between a patient's experience of illness and the clinical narrative produced by the physician. She analyzes the way in which physicians return the patient's story to the patient by giving back an interpreted version of that story in the forms of a diagnosis, a suggestion of therapy or abstinence, or reassurance.

Hunter wants physicians to hear, acknowledge, and narrate the full texture of their patients' lives, and she has made an extraordinary contribution to clinical medicine by demonstrating in such detail the means that already exist in hospital medicine for taking account of patients' minds and lives as well as their bodies.

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EDWARD NORBECK and MARGARET LOCK, eds. *Health, Illness, and Medical Care in Japan: Cultural and Social Dimensions.* 188 pp. Honolulu, Hawaii: University of Hawaii Press, 1987. Price $21.00.

Reviewed by ANN BOWMAN JANNETTA

Health, Illness, and Medical Care in Japan: Cultural and Social Dimensions, edited by Edward Norbeck and Margaret Lock, is a

collection of seven essays dealing with selected topics related to health and illness in contemporary Japan. The authors — five anthropologists and one political scientist — are interested in Japanese attitudes towards health, illness, and medical care. Margaret Lock's introductory chapter discusses the concept of "medicalization" — a term that is widely used in anthropological discourse but which resists precise definition. In this volume the term is used to describe the extension of medical approaches and interventions into life situations where there is no obvious pathology. Medicalization is a prominent theme in almost all of the articles, and, according to the authors, is well advanced in Japan and has produced a rising demand for medical services of all kinds.

Whatever the problems of health and illness in contemporary Japan, they must be viewed within the context of Japan's postwar "health miracle." William Steslicke's chapter on "The Japanese State of Health" provides this context for the reader. He documents the epidemiological shift in Japan from acute infectious to chronic degenerative diseases, and Japan's transition from high to low mortality rates. Today Japan has the highest life expectancy and the lowest infant mortality rates in the world — a remarkable achievement by any standard — and many of Japan's current health problems are a direct consequence of this success.

Christie Kiefer's chapter on "Care of the Aged" discusses the consequences of longer life expectancy. She presents a chilling account of the speed with which new medical technologies have produced a large and dependent elderly population that faces what the Japanese call "the ugly decline." Susan O. Long's chapter on "Health Care Providers" analyzes the historic relationship between Japan's influential community of physicians and the government health bureaucracy. David A. Reynolds's essay discusses "Japanese Models of Psychotherapy" including two — the Morita and Naikan therapies — which are distinctively Japanese.

Two of the essays, by Lock and Nancy R. Rosenberger, consider the relationship between social problems and health problems that are peculiar to women. In "Protests of a Good Wife and Wise Mother: The Medicalization of Distress in Japan," Lock claims that what is essentially a social problem — limited opportunity for women to participate as individuals in Japanese society — is exhibited as a medical problem, which is culturally more acceptable. Rosenberger suggests that in Japan "middle-aged women use ideas and actions about menopause to control their image in relation to

the household" (p. 181). Village women who play an important economic role in their households regard the menopause as the end of a woman's reproductive but not her productive role in the household. City women are more likely to regard menopause as a time when household responsibilities should diminish so that they can participate in activities outside the household.

The essays in this volume cover topics of universal interest, have excellent bibliographies, and contain a wealth of information that should be of interest to public health specialists, medical historians, sociologists, medical and cultural anthropologists, and journalists who write about contemporary affairs.

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WILLIAM J. ELLOS. *Ethical Practice in Clinical Medicine.* 172 pp. New York: Routledge, Chapman & Hall, 1991. Price $15.95.

Reviewed by DAVID G. SMITH

The growth in medical ethics literature over the past two decades creates serious difficulties for the practicing physician or medical student if he or she desires a quick primer. During the 1970s, the typical book was an anthology of specific articles dealing with topics such as autonomy, beneficence, truth-telling, euthanasia, abortion, and research. A brief introduction to each topic was usually written by a single author and most such texts included pertinent clinical cases. The next generation of texts explored the philosophical foundations of medicine and the doctor-patient relationship.

A new generation of texts has now started to explore some basic philosophical approaches to dilemmas in medicine. The discussion of the applications of casuistry and virtue to medical ethics is extremely interesting but clearly beyond the scope of most practicing physicians who require a quick introduction and update. From a more practical perspective, Jonsen, Siegler, and Winslade have published a manual of clinical ethics along the line of a number of quick reference sources to guide action at the bedside (*Clinical Ethics,* Macmillan, 1986). Where then should *Ethical Practice in Clinical Medicine,* by William Ellos, be inserted? Is it a quick refer-

ence or is it more fundamental in its orientation? The answers to these questions are important if this book is to find a niche in an already crowded field.

The introduction to the book states that ". . . because this text is designed to be used by the busy health practitioner, the theoretical material is kept clear, brief and to the point . . . the clinical cases [are] crisp and concise . . . . " Using this as my introduction, I started to read the chapter on the Platonic Foundation. The concept of virtue is presented along with several case studies. One case is of a physician confronted with a terminally ill patient who requests an increase in her "pain killing drugs." Ellos tries to swirl a discussion on the Platonic dialogues around this dilemma utilizing concepts of virtue, the lawmaker, moderation, and courage. As is true of most cases provided in the book, a few provocative questions follow the case presentation with little or no attempt to use the basic philosophical discussion. These cases may be good to provoke a discussion in a classroom setting, but a "busy health practitioner" is clearly not going to spend a tremendous amount of time trying to apply the thin discussion of the Platonic dialogues to these cases; nor could he or she without additional reading from other sources. A practical ethical approach to a patient requesting a suicidal dose of painkillers would deal with the principle of double effect and the current legal prohibitions against physician assisted suicide. Although reading and understanding Plato may be illuminating, busy practitioners usually need more directed reading.

A related concern is the relevance of some of the philosophical foundations to discourse in medical ethics. Although interesting in a basic course surveying the development of moral philosophy, there is little doubt that the basic schools covered in this text have little immediate relevance to the bedside dilemmas.

A small criticism relates to errors in some of the case presentations. For example, on page 60 a physician is quoted on the problems of working within a HMO setting. She is alleged to have said that ". . . another problem was that I was under pressure to encourage my patients to undergo procedures, since that's where the money's at . . . . " Actually, the opposite is true when working within a prospective reimbursement setting. On page 67, the author states that ". . . in their state, the law prohibits shutting off the respirator until the patient is weaned . . . . " I am not aware of any state which precludes a competent adult from having his request for discontinuation of a ventilator respected. A reference or some

note concerning this assertion would be helpful. On page 88, a "serum 12" probably is a "vitamin B12" level. Some of the cases beg for greater discussion concerning the appropriateness of the choices. For example, a radiologist discusses the results of a X-ray showing newly diagnosed cancer with a patient; a resident sabotages a decision by patient and family concerning extubation of a seriously ill patient; a physician acts to restrict care because of the fear of administrative sanctions concerning the loss of revenue through continued care to the patient.

Despite some of the above problems, the cases represent some of the most typical dilemmas which rarely get the serious attention in the academic journals. Although it would be easy to dismiss these clinical vignettes as just examples of bad cases which should not be used in formal ethics teaching, they represent the bread and butter reality of most practicing clinical ethicists.

Several questions need to be answered. Who should buy and read this book? This book would be most useful as a basic text in an undergraduate course supplemented by additional reading in the specific philosophical traditions. As a coordinator of a course in medical ethics at a medical school, I am not sure that this text would work well in a required course with limited course hours. I am quite certain that this book is woefully inadequate for the "busy health practitioner," not because such an individual would not benefit from reading this text, but because it lacks any of the specific guidelines developed for such ethical problems as DNR decisions, advance directives, withdrawing or withholding life support, durable power of attorney, etc. Most clinicians should probably consult pertinent articles in the clinical literature or access the information through their local ethics consultant or ethics committee. However, this book may be quite appropriate for those autodidacts who require a basic philosophical primer as a prelude to an immersion in a more in-depth analysis.

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Memoir of C. William Hanson, Jr., 1929–1991

ORVILLE HORWITZ

C. William (Bill) Hanson, Jr. was born in Poughkeepsie, New York, on 8 July 1929. He graduated from Cornell University in 1951, and then attended the University of Pennsylvania School of Medicine, obtaining a degree in medicine in 1955. After graduating from medical school, Bill spent the rest of his professional life — except for the years 1957–1959 which he spent in Athens, Greece, and Washington, D.C., as an officer of the United States Navy — affiliated with the Hospital of the University of Pennsylvania (HUP). In addition, he was also once associated with the CIA.

I first met Bill in 1954, when he was a medical student. I later knew him in his capacity as an intern, a resident, a research fellow, a chief medical resident, and a tenant in my own office. He became a life-long friend as well as my personal physician. We were members together of the "Sons of the Copper Beeches," a Sherlock Holmes Society in which Bill usually won all the quiz prizes.

Bill's most memorable characteristic was his consistently superb set of values. To him, the *care* of the patient was always the most important consideration in medicine. Bill was always very conscious of this point. He was also an excellent teacher and edited a splendid book entitled *Toxic Emergencies* (New York: Churchill Livingstone, 1984). He knew the medical literature well and was very interested in research, but not in the performance thereof. His major teaching and clinical responsibilities, as he once listed them, were:

1. Attending physician in emergency medicine, with two-to-four students per month.
2. Attending rounds in Medical In-Patient Service one month per year.
3. Various lesser commitments, including acting medical director of the Student Health Service; member of the Infectious Disease Section; emergency room physician and director

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> of Emergency Services; recording secretary of the Medical Board and Executive Committee; member of the Professional Quality Assurance Committee; member of the Credentials Committee; member of the Technical Advisory Committee, the Philadelphia Poison Control Center; associate medical command physician, the Trauma Service; and innovator and director of the new Health Evaluation Center.

Bill was always available to chair any committee which was known for its drudgery, and about which no one else was too enthusiastic. His presence and directorship of these committees gave them prestige and, unbelievably, popularity. He was a favorite medical consultant of physicians and surgeons, certainly for their patients, and usually for themselves.

Bill married the former Ann Morgan in 1954, and fathered a family of five, fine children — the eldest of whom, C. William Hanson, III, is an associate in anesthesiology at HUP. Bill and his wife Ann were active at HUP as well as in the College of Physicians of Philadelphia, where Bill was chairman of the Program Committee.

In closing, I quote from the annual report of the Foundation for Vascular-Hypertension Research, of which Bill was a staff member:

> Members of the foundation and especially members of the staff of the Hospital of the University of Pennsylvania and, most especially, his patients, were shocked to learn of the sudden death of Dr. C. William Hanson on Saturday, September 28, 1991. It is often stated that no one is irreplaceable, but Bill Hanson came as close as anyone to that category. We have all lost a magnificent man, a loyal friend, and a truly great physician.

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EXAMPLES

William H. Helfand, *Medicine and Pharmacy in American Political Prints* (Madison, Wis.: American Institute of the History of Pharmacy, 1967), p. 35.

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